DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

accepted

PREVIEW 08/09/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
POC #1	445259	A. BUILDING _____ B. WING _____	C 07/30/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUMMIT VIEW OF LAKE CITY, LLC	244 INDUSTRIAL PARK RD LAKE CITY, TN 37769

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS Investigation of complaint #30197 was completed at Summit View of Lake City, LLC on July 26, 27, and 30, 2012. Based on survey findings the facility was cited an Immediate Jeopardy (a situation in which the provider's non-compliance with one or more requirements of participation has caused, or is likely to cause serious harm, injury, impairment, or death) at F157, F224, F225, F250, F272, F281, F309, F323, and F490, all scope and severity level of a "J", for failure to assess and notify the physician of recurrent unsafe behaviors, failure to prevent neglect, failure to thoroughly investigate recurrent elopement attempts and/or an elopement, failure to provide required social services, failure to revise the care plan to address recurrent unsafe behavior, failure to timely communicate recommendations for an increase in an antipsychotic medication and failure to provide adequate supervision and/or security device to prevent elopement for one resident (Resident #3) of seven sampled residents. A partial extended survey was completed on July 30, 2012. The Administrator and Director of Nursing were informed of the Immediate Jeopardy on July 30, 2012, at 12:38 p.m., in the Administrator's office. Substandard Quality of Care was cited under F224 J, F225 J, F250 J, F309 J, and F 323 J. The Immediate Jeopardy was effective June 17, 2012, through July 24, 2012. The survey findings on July 30, 2012, revealed	F 000		8/17/2012

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Administrator 8/17/2012

For deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 000	Continued From page 1 corrective actions removed the immediacy of the jeopardy but non-compliance continues at a scope and severity of a "D" level for monitoring of corrective actions through the facility's Quality Assurance/Performance Improvement Program. The facility is required to submit a plan of correction for all cited deficiencies.	F 000		
F 157 SS=J	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.	F 157	157 Requirement: The facility will immediately inform the resident; consult with resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (***i.e., a deterioration in health, mental or psychosocial status in either life threatening conditions or clinical complications***); a need to alter treatment significantly (***i.e., a need to discontinue and existing form of treatment due to adverse consequences, or to commence a new form of treatment***) ; or a decision to transfer or discharge the resident from the facility as specified in *483.12(a). The facility will also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in *483.15(e)(2); or a change in resident	8/17/2012

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F 157	Continued From page 2 The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on review of facility policy, medical record review, and interview, the facility failed to notify the physician of recurrent elopement attempts for one resident (#3) with identified elopement risk behaviors of seven sampled residents. The facility's failure to notify the physician of recurrent elopement attempts by Resident #3 resulted in an actual elopement and Immediate Jeopardy (a situation that is likely to cause serious injury, harm, impairment, or death). The Immedidate Jeopardy was effective on June 17, 2012, through July 24, 2012. The Administrator and Director of Nursing were notified of the Immediate Jeopardy on July 30, 2012, at 12:38 p.m. in the Administrator's office. The findings included: Review of facility policy, Guidelines for Assessing a Change in a Resident's Condition Status, dated June 2008 revealed, "...Our facility shall promptly notify the...Attending Physician,...of changes in the resident's medical/mental condition and/or status...The Nurse supervisor/Charge Nurse will notify the resident's Attending Physician or On-Call Physician when there has been: a. An accident or incident involving the resident...Instructions to notify the physician of	F 157	rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility will record and periodically update the address and phone number of the resident's legal representative or interested family member. Corrective Action All of the clinical staff was in serviced on Notification of the Physician by 8/14/2012 by the Director of Nurses, the Administrator and or Unit Supervisor. All clinical staff was also in serviced on the use of the twenty-four hour report by the Director of Nurses, the Administrator and or the Unit Supervisor by 8/14/2012. The Interdisciplinary Care Plan team which consist of the Director of Nurses, MDS Coordinators, Social Services Director, Environmental Services Director , Dietary Manager , Wound Care Nurse and Activities Director were in serviced by the Administrator by 8/14/2012 on Notification of Physician and or Nurse Practitioner; and use of the 24 hour report for communication. The twenty- four hour report will be collected each business day by the Unit Supervisor and	

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F 157	Continued From page 3 changes in the resident's condition..." Resident #3 was admitted to the facility on April 10, 2012, with diagnoses including Dementia and Unspecified Bipolar Disorder. Medical record review of a hospital History and Physical dated March 25, 2012, revealed, "...admitted by neurosurgery services for subarachnoid hemorrhage...underwent aneurysm clipping...resulting in waxing mental status changes, psychosis...discharged again in stable condition on 3-21-12...Daughter states,..increased symptoms of agitation and mental status changes...picking at things and has been talking about hurting...self...asked for sharp objects and a knife and talked about cutting...wrist...Assessment and Plan:...concerns about suicidal ideations. Suicide precautions will be initiated..." Medical record review of an admission Minimum Data Set (MDS) dated April 17, 2012, revealed a Brief Interview for Mental Status (BIMS) score was seven (moderate mental impairment), felt down, depressed, or hopeless nearly every day, and rejected care one to three days. Continued review revealed the resident ambulated with supervision, was steady at all times with transfers and ambulation, and required limited to extensive assistance with other activities of daily living. Medical record review of a care plan dated April 23, 2012, revealed, "...Notify MD (Medical Doctor) if behavior interferes with functioning..." Medical record review of a nurse's note dated June 17, 2012, at 2:00 p.m., revealed, "called to	F 157	reviewed to identify events that require notification. Those items that are identified the facility will immediately inform the resident: consult with resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status compliance and results will be reported to the Interdisciplinary Care Plan Team which consist of the Director of Nurses, MDS Coordinators, Social Services Director, Environmental Services Director, Dietary Manager, Wound Care Nurse and Activities Director; whom will also review for effectiveness. The Director of Nurses will review results to ensure compliance. All in services will be added to the new employee orientation training to educate new employees on Notification 4. The Director of Nursing or Unit Supervisor will review the twenty-four	

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F 157	Continued From page 4 resident's room screen removed from window and resident attempting to climb out redirected while staff was attempting to fix window but resident continues to attempt to leave...will cont (continue) to monitor." Medical record review revealed no documentation regarding notification of the physician. Medical record review of a nurse's note dated June 17, 2012, at 9:30 p.m., revealed, "Responded to CNA (Certified Nursing Assistant) calling out. Went to resident's room to see CNA holding resident to keep (resident) from falling out of open window onto the ground. Resident had pushed screen out and attempted to climb out of window. This nurse was told the resident had made the same attempt earlier today...Will monitor." Medical record review revealed no documentation regarding notification of the physician. Medical record review of a physician's order dated June 19, 2012, revealed, "...NP (Nurse Practitioner) to be notified if pt (patient) continues to be aggressive and agitated or any delusions, hallucinations." Medical record review of a nurse's note dated July 14, 2012, revealed, "@ (at) 1 pm (1:00 p.m.) window alarm sounding resident with one leg out window redirected back in window...Helped resident to bed covered with blanket and exited room." Medical record review of a nurse's note dated July 14, 2012, at 1:30 p.m., revealed, "resident continuing to attempt to climb out window...RN (Registered Nurse) notified of situation...will continue to monitor." Medical record review revealed no documentation	F 157	...our reports daily to ensure that the ...acility immediately informs the ...esident: consult with resident's ...hysician; and if known, notify the ...esident's legal representative or an ...nterested family member when there ...s an accident involving the resident ...which results in injury and has the ...otential for requiring physician ...ntervention; a significant change in ...he resident's physical, mental, or ...psychosocial status. The twenty- four ...hour report will be brought to the ...orning Quality Assurance Meeting ...by the Registered Nurse Supervisor ...and/or the Unit Supervisor. The ...Director of Nurses and Social Services ...director will perform three chart ...reviews a week to ensure that proper ...notification is being addressed. The ...findings of the reviews will be ...discussed in the monthly Quality ...Assurance Meeting for three months ...to ensure compliance is met. The ...Administrator or Director of Nursing ...will lead the Quality Assurance ...Meeting each month to ensure that the ...items that are being reviewed are ...effective and to identify any additional ...areas of concerns that may be ...presented or as a result of the Quality ...Assurance Meeting going forward.	

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F 157	Continued From page 5 regarding notification of the physician. Medical record review of a nurse's note dated July 16, 2012, at 9:00 a.m., revealed, "...wandering...exit seeking shaking door to leave...will cont to monitor." Medical record review of a nurse's note dated July 17, 2012, at 6:15 p.m., revealed, "...Exit seeking, trying to remove screen in window and climb over fence on patio (a courtyard enclosed by a six foot fence). Unable to redirect..." Medical record review revealed no documentation regarding notification of the physician. Medical record review of a nurse's note dated July 19, 2012, at 7:40 p.m., revealed, "...CNA (#2) came running over to South Station where I was on a med (medication) cart...said (resident) was out side, over at apartment complex...(CNA #1) was on lunch and came driving back to nursing home and seen (resident) running up the road to apartment complex...saw (resident) go into apartment #124...the police came and helped get (resident) back to (secure unit)..." Telephone interview with the resident's physician (Medical Doctor) (M.D. #1) on July 30, 2012, at 12:20 p.m., in the administrator's office and in the presence of the Director of Nursing (DON) and the Administrator, revealed M.D. #1 was unaware of the resident's attempts to elope from the facility on June 17, 2012, and July 14, 2012, and confirmed the facility had failed to notify M.D. #1 regarding the resident's recurrent elopement attempts. In summary, the facility failed to notify M.D. #1 following elopement attempts by Resident #3 on	F 157		

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F 157	Continued From page 6 June 17, 2012, and July 14, 2012, resulting in the resident's actual elopement from the facility on July 19, 2012. Corrective actions which removed the immediacy of the jeopardy, included one on one supervision of the resident while installation of additional alarms to the windows on the secure unit was completed, assessment and care plan revision for the resident and other resident's at risk, and revision of policies and procedures regarding identification, investigation, and notification of unusual occurrences including abuse and/or neglect, and education of nursing staff regarding notification regarding unsafe behaviors. The surveyor verified the corrective actions on July 30, 2012, by observation, medical record review, policy review, and interview. Non-compliance continues at a "D" level for monitoring the facility's Quality Assurance/Performance Improvement Program. The facility is required to submit a Plan of Correction. C/O: #30197	F 157		
F 224 SS=J	483.13(c) PROHIBIT MISTREATMENT/NEGLECT/MISAPPROPRIATION The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.	F 224	1224 Requirement: The facility will develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.	8/17/2012

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F 224	Continued From page 7 This REQUIREMENT is not met as evidenced by: Based on review of facility policy, medical record review, review of facility investigation, review of window alarm monitoring documentation, observation, and interview, the facility failed to prevent neglect for one resident (#3) with identified elopement risk behaviors of seven sampled residents. The facility's failure to prevent neglect for Resident #3 with repeated elopement attempts and actual elopement resulted in Immediate Jeopardy (a situation in which the provider's non-compliance with one or more requirements of participation has caused, or is likely to cause serious harm, injury, impairment, or death). The Administrator and Director of Nursing were notified of the Immediate Jeopardy on July 30, 2012, at 12:38 p.m., in the Administrator's office. The Immediate Jeopardy was effective on June 17, 2012, through July 24, 2012. The findings included: Review of facility policy, Preventing Resident Abuse, dated August 2008 revealed, "Our facility will not condone any form of resident abuse and will continually monitor our facility's policies, procedures...to assist in preventing abuse...Our abuse prevention/intervention program includes, but is not necessarily limited to...Assessing, care planning, and monitoring residents with needs and behaviors that may lead to conflict or neglect;	F 224	Corrective Action: 1. All staff was in-serviced on Abuse by the Administrator Director of Nurses or Unit Supervisor by 8/14/2012. All clinical staff was in serviced on Neglect, Identification, Investigation, Documentation, Patient Assessment, Addressing Recommendations Timely, and Notification by 8/14 /12 by the Director of Nurses, the Administrator and or Unit Supervisor. All clinical staff was also in serviced on the use of the twenty-four hour report by the Director of Nurses, the Administrator and or Unit Supervisor by 8/14/2012. The Interdisciplinary Care Plan team which consist of the Director of Nurses, MDS Coordinators, Social Services Director, Environmental Services Director , Dietary Manager , Wound Care Nurse and Activities	

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F 224	Continued From page 8 Assessing residents with signs and symptoms of behavior problems and developing and implementing care plans to address behavioral issues...Involving qualified psychiatrists and other mental health professionals to help the staff manage difficult or aggressive residents...Identifying areas within the facility that may make abuse and/or neglect more likely to occur...and monitoring these areas regularly...Striving to maintain adequate staffing on all shifts to ensure that the needs of each resident are met...Encouraging all personnel...to report any signs or suspected incidents of abuse to facility management immediately...To help with recognition of incidents of abuse, the following definitions of abuse are provided...Neglect is defined as failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness..." Resident #3 was admitted to the facility on April 10, 2012, with diagnoses including Dementia and Unspecified Bipolar Disorder. Medical record review of a hospital History and Physical dated March 25, 2012, revealed, "...admitted by neurosurgery services for subarachnoid hemorrhage...underwent aneurysm clipping...resulting in waxing mental status changes, psychosis...discharged again in stable condition on 3-21-12...Daughter states...increased symptoms of agitation and mental status changes...picking at things and has been talking about hurting...self...asked for sharp objects and a knife and talked about cutting...wrist...Assessment and Plan:...concerns about suicidal ideations. Suicide precautions will be initiated..."	F 224	Director were in serviced by the Administrator by 8/14/2012 on Neglect, Identification, Investigation, Documentation, Patient Assessment, Notification; and use of the twenty four hour report for communication. The twenty- four hour report will be collected each business day by the Registered Nurse Supervisor and or the Unit Supervisor and reviewed to identify neglect. Items that are identified will be reviewed for compliance and results will be reported to the Interdisciplinary Care Plan Team which consist of the Director of Nurses, MDS Coordinators, Social Services Director, Environmental Services Director, Dietary Manager, Wound Care Nurse and Activities Director; which will also review for effectiveness. All in services will be added to the new employee orientation training to educate new employees on Neglect. 4. The Director of Nursing or designee will review the twenty-four hour reports daily to ensure that neglect is not identified. The twenty- four hour report will be brought to the daily Quality Assurance Meeting which is	

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F 224	Continued From page 9 Medical record review of a nurse's note dated April 14, 2012, at 2:05 p.m., revealed the resident was admitted to a room in the facility's secure unit and included, "...confused, ambulates with steady gait..." Medical record review of an undated Elopement Risk Form revealed a score of 10 and included, "...Total Score: 10 or Higher = (equals) At risk for elopement...Placed on Greenbriar (secure) unit for increased Elopement Risk..." Medical record review of a nurse's note dated April 14, 2012, at 11:00 p.m., revealed, "...Has episodes of exit-seeking. Will continue to monitor." Medical record review of an admission Minimum Data Set (MDS) dated April 17, 2012, revealed a Brief Interview for Mental Status (BIMS) score was seven (moderate mental impairment), felt down, depressed, or hopeless nearly every day, and rejected care one to three days. Continued review revealed the resident ambulated with supervision, was steady at all times with transfers and ambulation, and required limited to extensive assistance with other activities of daily living. Medical record review of a nurse's note dated April 18, 2012, at 8:00 a.m., revealed, "...wanders continuously. Wants to go home..." Medical record review of a nurse's note dated April 23, 2012, at 8:00 p.m., revealed, "...continues to pace up and down...unit aimlessly..." Medical record review of the care plan dated April 23, 2012, revealed, "Problem...Special Care Unit	F 224	[illegible]eld on business days by the Unit Supervisor. On holidays and weekends he twenty four hour report will be eviewed by the unit coordinator and communicated via copy of the twenty our hour report to the Quality Assurance Meeting on the next usiness day. The Director of Nurses nd Social Services director will erform three chart reviews a week to nsure residents are free from neglect. The findings of the reviews will be iscussed in the monthly Quality Assurance Meeting for three months to ensure compliance is met. The Administrator or the Director of Nurses will lead the Quality Assurance Meeting each month to ensure that the items that are being reviewed are effective and to identify any additional areas of concerns that may be presented or as a result of the Quality Assurance Meeting going forward.	

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F 224	Continued From page 10 Placement due to increasing confusion...diminished decision abilities r/t (related to) safety Goals Will know: family, staff faces, room location Interventions: Special Care Unit...Keep environment free of hazards...Assist in emergencies." Continued review revealed no intervention regarding staff supervision while in the resident's room and/or monitoring the window alarm. Medical record review of a nurse's note dated May 3, 2012, at 9:00 p.m., revealed, "...shuts...self in room and slides chair against door..." Medical record review of a nurse's note dated May 5, 2012, at 3:00 p.m., revealed, "...Puts chair under door knob per night shift..." Medical record review of a physician's order dated May 10, 2012, revealed, "Change Haldol (antipsychotic medication) to 2 mg (milligrams) po bid (by mouth twice daily)." Medical record review of a nurse's note dated May 24, 2012, at 3:00 p.m., revealed, "Severely agitated - Focused on going home...will continue to monitor." Medical record review of a nurse's note dated May 29, 2012, at 9:00 a.m., revealed, "...wandering in hallway stating 'I want to leave here I don't belong here' exit seeking...continue to monitor." Medical record review of a nurse's note dated May 31, 2012, at 10:50 p.m., revealed, "...CNAs (Certified Nursing Assistants) said (resident) had been exit-seeking earlier. Will monitor." Medical record review of a nurse's note dated June 6, 2012, at 9:00 a.m., revealed, "...went out to patio and threatening to climb fence..."	F 224		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445259	A. BUILDING _____ B. WING _____	C 07/30/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 224	Continued From page 11 Medical record review of a nurse's note dated June 10, 2012, revealed, "(6A-6P) (6:00 a.m. -6:00 p.m.)...unable to concentrate any length of time on any one thing..." Medical record review of a nurse's note dated June 17, 2012, at 2:00 p.m., "called to resident's room screen removed from window and resident attempting to climb out redirected while staff was attempting to fix window but resident continues to attempt to leave...will cont (continue) to monitor." Medical record review of a nurse's note dated June 17, 2012, at 9:30 p.m., revealed, "Responded to CNA calling out. Went to resident's room to see CNA holding resident to keep (resident) from falling out of open window onto the ground. Resident had pushed screen out and attempted to climb out of window. This nurse was told the resident had made the same attempt earlier today...Will monitor." Medical record review of a physician's order dated June 18, 2012, at 6:00 a.m., revealed, "Family intervention meeting 6-18-12 @ (at) 2 pm." Medical record review revealed no documentation regarding a family intervention meeting. Medical record review of a Nurse Practitioner Progress note dated June 19, 2012, revealed, "...Nursing staff notified of increased agitation...appears extremely agitated and has delusions, combative...Schizoaffective disorder..." Medical record review of a physician's order dated June 19, 2012, revealed, "...NP (Nurse Practitioner) to be notified if pt (patient) continues to be aggressive and agitated or any delusions, hallucinations."	F 224		

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OMB NO. 0938-0391

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F 224	Continued From page 12	F 224		

Medical record review of a nurse's note dated June 19, 2012, at 9:00 p.m., revealed, "...Trying to climb fence at patio (enclosed courtyard). Unable to redirect..."

Medical record review of an Elopement Risk assessment dated July 3, 2012, revealed the resident had no history of elopement attempts in the past six months, a score of 9, and included,"Total Score: 10 or higher = (equals) at risk for elopement..."

Medical record review of the care plan revealed, "...Plan of Care
Comments...7-3-12...Comprehensive care plan reviewed and updated...with IDT (interdisciplinary Team) for quarterly CP (care plan) meeting." Continued review revealed no revision of the care plan regarding the resident's recurrent elopement attempts.

Medical record review of a Psychotropic Medication Evaluation dated July 4, 2012, at 12:01 p.m., revealed, "...presents with severe insomnia...staff reported episodic mood swings...some inc (increased) delusions...Rationale for Recommendations...also may inc (increase) haldol 2 mg 1/2 tab (tablet) afternoon in addition to bid dose pm (as needed)..." Continued review revealed the recommendations were approved by a nurse practitoner on July 20, 2012.

Medical record review of a nurse's note dated July 6, 2012, at 8:00 a.m., revealed, "...wandering in hallway Asking repetively (repetitive) questions about going home...will monitor." Medical record

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 224	Continued From page 13 review of a nurse's note dated July 11, 2012, at 2:00 p.m., revealed, "Resident with agitation exit seeking attempted to follow (name) off the floor...redirection unsuccessful...will cont (continue) to monitor." Medical record review of a Psychotropic Medication Management Progress Note dated July 13, 2012, at 12:45 p.m., revealed, "...appeared vigilant and paranoid. Staff reported '...has been crazy'...staff reported increased paranoia as dementia escalates. Current c/o (complaint) inc (include) physical aggression and irritability. Plan: increase haldol 2 mg tid (three times daily)...Indications for next visit: Acute Behavioral/Medical Problem...Delusions...Judgment Impaired...Ambulatory ...SI/HI (suicidal/homicidal ideation) Unable to assess due to patient's cognitive impairment..." Continued review revealed the Progress Note was not reviewed by a Physician or a Nurse Practitioner until July 23, 2012, (ten days later) and included, "...Accept..." Medical record review of a physician's order dated July 23, 2012, revealed, "Haldol (an antipsychotic medication) 1 mg @ noon." Medical record review of a nurse's note dated July 13, 2012, at 5:35 p.m., revealed, "Resident hollering that (resident) wanted to (go) home, that we have no right to keep...against (resident's) will...Going outside in enclosed area and attempting to climb fence...one on one monitoring in process..." Interview with the Director of Nursing (DON) on July 30, 2012, at 12:15 p.m., in a conference	F 224		

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F 224	Continued From page 14	F 224		

room, revealed the DON was unaware of the initiation of one on one supervision and unable to determine the duration of the one on one supervision documented in the nurse's note on July 13, 2012.

Medical record review of a nurse's note dated July 14, 2012, revealed, "@ 1 pm (1:00 p.m.) window alarm sounding resident with one leg out window redirected back in window...Helped resident to bed covered with blanket and exited room." Medical record review of a nurse's note dated July 14, 2012, at 1:30 p.m., revealed, "resident continuing to attempt to climb out window...RN (Registered Nurse) notified of situation...will continue to monitor." Medical record review of a nurse's note dated July 16, 2012, at 9:00 a.m., revealed, "...wandering...exit seeking shaking door to leave...will cont to monitor." Medical record review of a nurse's note dated July 17, 2012, at 9:00 a.m., revealed, "...continuously asking...when am I going home...will cont to monitor." Medical record review of a nurse's note dated July 17, 2012, at 6:15 p.m., revealed, "...Exit seeking, trying to remove screen in window and climb over fence on patio. Unable to redirect..."

Medical record review of a nurse's note dated July 19, 2012, at 2:30 p.m., revealed, "...Res. (resident) crying today...wanted to go home. At one time...yelled...and ran out back door...Will cont. to monitor behavior and attempt to redirect."

Medical record review of a nurse's note dated July 19, 2012, at 7:40 p.m., revealed, "(name CNA) (#2) came running over to South Station where I was on a med (medication) cart...said

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 224	Continued From page 15 (resident) was out side, over at apartment complex...(CNA #1) was on lunch and came driving back to nursing home and seen (resident) running up the road to apartment complex...saw (resident) go into apartment #124...the police came and helped get (resident) back to (secure unit)..." Medical record review of the Medication Administration Record dated July 2012 revealed the resident was administered Haldol 2 mg at 8:00 a.m. and 8:00 p.m., from July 1, 2012 through July 23, 2012. Continued review revealed administration of Haldol 1 mg at 12:00 p.m., was initiated July 24, 2012, twenty days following the first recommendation (of July 4, 2012) to increase the resident's medication, ten days after the resident's third elopement attempt (on July 14, 2012), and five days after the resident's elopement (on July 19, 2012). Review of a facility investigation for a Notification of Unusual Occurrence Check List revealed, "...Date of Occurrence: 7/19/2012 Time: 8 p.m. Location: (the room the resident exited had a line drawn through it and the room the resident was moved to after the elopement was identified)...Original care plan updated with NEW INTERVENTIONS: Yes...New interventions one on one sitter...moved to room (another room on opposite side of hallway and where window exits to courtyard)...Was the facility's policy implemented at all times? Yes...Supervisors Comments: Upon investigation it was found...resident pushed the window in (resident's) room open and screen out and went out window across the street to the apartments next door, about 50-75 yards...back within 10-15 mins	F 224		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 224	Continued From page 16 (minutes)..." Review of a Post Fall Review Form dated July 19, 2012, revealed, "Date of Fall..." Continued review revealed the word "fall" had a line drawn through it and included, "Location of fall Resident's room went out window...Patient opens window in room and elopes from facility. Window alarm inaudible from hallway with door to room closed...Interdisciplinary Team Review/Recommendations...Ensure Alarm on Window Working...Resident was out of facility approximately 10-15 mins (estimate)...Approximate Distance 50-75 ft (feet)." Continued review revealed the form was not dated or signed. Review of a "Monthly Window Alarm Test for Greenbriar" (secure unit) dated 2012 revealed the alarm in the resident's window was tested in June and included, "OK." Continued review revealed no documentation for testing window alarms on the secure unit in July 2012 as of July 27, 2012. Review of a facility investigation and a witness statement dated July 19, 2012, revealed, "I...(RN #1) was working the med cart on South Station, about 8 pm (p.m.)...CNA came running...told me (resident) was out side over at apartment complex...I ran over to Greenbriar (secure unit) to see if it was really (resident), when I went into Greenbriar...(Licensed Practical Nurse) (LPN) #1 was doing...med cart, LPN #1 did not know that (resident) was gone. I went to dinning (dining) room no (resident), I ran down the hall to (resident's) room, the door was shut, I could not hear the alarm, I opened the door and I could hear the alarm but it was not very loud, the	F 224		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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F 224	Continued From page 17 window was open...(resident) was gone, I ran to the apartment complex next door the police was bring (bringing) (resident) back to the nursing home in (police) car..." Review of a facility investigation and LPN #1's statement dated July 19, 2012, revealed, "...at approximately 0740 pm- 800 pm (7:40 p.m.-8:00 p.m.) I was in the process of self-orienting myself to e-charting and the e-mar (electronic charting and electronic Medication Administration Record)...at the desk...(RN #1) enters the unit and says...has been told a resident has eloped from the unit. I...was unaware of this...and we both proceeded rapidly to (resident's) room...An alarm, which was inaudible standing immediately outside the closed door, was sounding...(resident) was returned to the unit by a law enforcement officer..." Review of the facility investigation and a statement by CNA #1 dated July 19, 2012, revealed, "While I was out on my lunch break I noticed (resident) running around in the yards over at the fairgrounds (an apartment complex). I asked if I could give...a ride back (resident) hit me 3 times. That's when I realized it was going to take more than me to get (resident) back...(CNA #2) was at the front door...to let some family members out...The family members followed us over and asked what (resident) looked like...They told me to get in with them and they would drive me around to see if I could find (resident). I happened to see a man across the street pointing towards an apartment...the woman that was with us said I'm a nurse let me take care of this. She knocked on the door and said she was calling the law. Her husband called 911. The cops showed	F 224		

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F 224	Continued From page 18 up and (RN #1) and (Maintenance Director) was walking over...the cop took (resident) over to the nursing home..." Review of the facility investigation dated July 25, 2012, revealed, "...Date of Alleged Event: 07/19/2012...was in own room, opened the window, and crawled out of window (resident)...running down the road...Resident had just left the facility when seen by the CNA...no more than 15 minutes...The LPN and the CNAs did not hear the alarm going off in the room due to the door was shut..." Observation on July 26, 2012, at 10:16 a.m., revealed the door to the resident's room was closed. Observation on July 26, 2012, at 2:07 p.m., revealed the resident asleep in bed. Continued observation revealed the resident's current room was the first room from the exit door to the courtyard and furthest from the nurse's station, and a fenced courtyard was visible through the resident's window. Observation on July 26, 2012, at 3:02 p.m., revealed the resident independently walked with a steady gait to the nurse's station and stated, "I wanna (want to) go home. I love you. Can I go home with you?" Observation on July 27, 2012, at 10:25 a.m., revealed the resident asleep on the bed and the door to the room was open. Interview with the Maintenance Director on July 27, 2012, at 11:57 a.m., in a conference room, revealed alarms had been placed on every window of the secure unit for at least two years. Continued interview revealed operation of the alarms was tested monthly, the alarm had been checked the evening the resident eloped (after	F 224		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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F 224	Continued From page 19 the elopement) and he stated, "...If you were at the desk (you) could not hear it. You'd have to be close to it. (There is) no way to adjust the volume." Interview with the Maintenance Director on July 27, 2012, at 12:17 p.m., in a conference room, revealed the Maintenance Director was unaware the resident had attempted to elope through the window of the resident's room prior to the elopement on July 19, 2012. Interview with CNA #1 on July 27, 2012, at 1:45 p.m., in a conference room, revealed CNA #1 had left the facility for lunch at approximately 7:00 p.m. and on returning from lunch observed the resident out of the facility. Continued interview revealed the resident was on the far side of the second street from the facility, and CNA #1 stated, "...I noticed (resident) right there on the side of the road straight across the street from (the) apartment where (resident) was at...hit me two to three times right up the side of the head...decided I needed more help...I got to the road to turn in here, looked back and saw (resident) running toward that apartment. Saw (resident) go up the steps...That shocked me that (resident) was that far and nobody noticed..." Medical record review of the resident's care plan and interview with MDS Coordinator #1 on July 27, 2012, at 2:05 p.m., in a conference room, revealed the care plan was the resident's current care plan. Continued interview confirmed the resident's care plan had not been revised to address the resident's recurrent attempts and history of elopement. Interview with the DON and the Administrator on July 27, 2012, at 2:20 p.m., revealed the DON	F 224		

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F 224	Continued From page 20 had no additional investigations regarding elopement attempts by the resident. Continued interview revealed the twenty-four hour communication book had no documentation regarding the resident's previous elopement attempts on June 17, 2012, at 2:00 p.m. and 9:30 p.m. Continued interview confirmed the facility had failed to provide adequate supervision and/or safety device to ensure the resident with recurrent elopement attempts did not elope from the facility. The DON stated, "...have spoken to all RN managers. All say they were unaware of (resident's) previous attempts to elope. The only knowledge (DON's) of resident's behavior was the elopement. Staff did not report barring the door with a chair or previous attempts to get out the window." Interview with NP #1 and the DON on July 30, 2012, at 12:00 p.m., in a conference room, (DON) revealed the evaluations and/or recommendations of the mental health provider were difficult to comprehend related to conflicting recommendations documented on the form, but in different sections of the form, completed by the mental health provider. Continued interview confirmed the facility failed to contact the mental health providers for clarification of the recommendations on the form completed by the mental health providers. Telephone interview with the resident's physician (M.D. #1) on July 30, 2012, at 12:20 p.m., in the Administrator's office and in the presence of the DON and the Administrator, revealed he was unaware of the resident's attempts to elope from the facility on June 17, 2012, and July 14, 2012, and confirmed the facility had failed to notify M.D.	F 224		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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F 224	Continued From page 21 #1 regarding the resident's recurrent elopement attempts. Continued interview with M.D. #1 revealed M.D. #1 was the facility's Medical Director, and confirmed the recommendations for changes in the resident's antipsychotic medication was not communicated or acted on timely. Continued interview revealed timely administration of the increased dose of antipsychotic medication may have improved the resident's behavior and prevented the resident's elopement on July 19, 2012. Telephone interview with a Psychiatric Nurse Practitioner (PNP) on July 30, 2012, at 4:05 p.m., and in the presence of the DON, revealed the PNP provides assessments of residents and stated, "...I take my assessments back to (mental health provider) and (mental health provider) follows up on communicating to facility what (my) recommendations are." Interview with the DON on July 30, 2012, at approximately 4:15 p.m., in the DON's office, confirmed the facility neglected to provide the care required by Resident #3. The DON stated, "...We missed every opportunity..." Corrective actions which removed the immediacy of the jeopardy, included one on one supervision of the resident while installation of additional alarms to the windows on the secure unit was completed, assessment and care plan revision for the resident and other residents at risk, and revision of policies and procedures and staff education regarding identification, investigation, and notification of unusual occurrences including abuse and/or neglect.	F 224		

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F 224	Continued From page 22 The surveyor verified the corrective actions on July 30, 2012, by observation, medical record review, policy review, and interview. Non-compliance continues at a "D" level for monitoring corrective actions through the facility's Quality Assurance/Performance Improvement Program. The facility is required to submit a plan of correction. Refer to F157 J.	F 224		
F 225 SS=J	C/O: #30197 483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the	F 225	Requirements: The facility will not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aid registry or licensing authorities. The facility will ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of	8/17/2012

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUMMIT VIEW OF LAKE CITY, LLC	2144 INDUSTRIAL PARK RD LAKE CITY, TN 37769

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F 225	Continued From page 23 State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on review of facility policy, medical record review, review of facility investigation, and interview, the facility failed to thoroughly investigate recurrent elopement attempts and/or an elopement for one resident (#3) with identified elopement risk behaviors of seven sampled residents. The facility's failure to investigate recurrent elopement attempts by Resident #3 resulted in an acutal elopement and Immediate Jeopardy (a situation that is likely to cause serious harm, injury, impairment, or death). The Administrator and Director of Nursing (DON) were notified of the Immediate Jeopardy on July 30, 2012, at 12:38 p.m. in the Administrator's office.	F 225	unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (**including to the State survey and certification agency**) The facility will have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or the Director of Nurses and to other officials in accordance with State law (**including to the State survey and certification agency**) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective actions will be taken.	

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PRINTED: 08/08/2012
FORM APPROVED
OMB NO. 0938-0391

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F 225	Continued From page 24 The Immediate Jeopardy was effective on June 17, 2012, through July 24, 2012. The findings included: Review of facility policy, Guidelines for Abuse Investigations, dated August 2007 revealed, "All reports of resident abuse, neglect and injuries of unknown source shall be promptly and thoroughly investigated by facility management...Individual conducting the investigation will, as a minimum...Review the completed 'Occurrence Report'...Review the resident's medical record...Interview the resident's Attending Physician as needed to determine the resident's current level of cognitive function and medical condition...Interview staff members...who have had contact with the resident during the period of the alleged incident...Review all events leading up to the alleged incident..." Review of facility policy Guidelines for Elopements dated 2008 revealed, "...It is the responsibility of all personnel to report any resident attempting to leave the premises...the Charge Nurse should...Complete the incident report..." Resident #3 was admitted to the facility on April 10, 2012, with diagnoses including Dementia and Unspecified Bipolar Disorder. Medical record review of a hospital History and Physical dated March 25, 2012, revealed, "...admitted by neurosurgery services for subarachnoid hemorrhage...underwent aneurysm clipping...resulting in waxing mental status changes, psychosis...discharged again in stable	F 225	Corrective Action: 1. All clinical staff was in serviced on Neglect, Identification, Investigation, Documentation, Patient Assessment, Addressing Recommendations Timely, and Notification by 8/14/2012 by the Director of Nurses, the Administrator and or Unit Supervisor. All clinical staff was also in serviced on the use of the twenty-four hour report for effective communication by the Director of Nurses, the Administrator and or Unit Supervisor by 8/14/2012. The Interdisciplinary Care Plan team which consist of the Director of Nurses, MDS Coordinators, Social Services Director, Environmental Services Director , Dietary Manager , Wound Care Nurse and Activities Director were in serviced by the Administrator by 8/14/2012 on Neglect, Identification, Investigation, Documentation, Patient Assessment, Notification; and use of the 24 hour report for communication. The twenty- four hour report will be collected each day by the Registered Nurse Supervisor and or the Unit Supervisor and reviewed to identify events that require investigation such	

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F 225	Continued From page 25 condition on 3-21-12 ...Daughter states...increased symptoms of agitation and mental status changes...picking at things and has been talking about hurting...self...asked for sharp objects and a knife and talked about cutting...wrist...Assessment and Plan:...concerns about suicidal ideations. Suicide precautions will be initiated..." Medical record review of a nurse's note dated April 14, 2012, at 2:05 p.m., revealed the resident was admitted to a room in the facility's secure unit and included, "...confused, ambulates with steady gait..." Medical record review of an undated Elopement Risk Form revealed a score of 10 and included, "...Total Score: 10 or Higher = (equals) At risk for elopement ...Placed on Greenbriar (secure) unit for Increased Elopement Risk..." Medical record review of a nurse's note dated April 14, 2012, at 11:00 p.m., revealed, "...Has episodes of exit-seeking. Will continue to monitor." Medical record review of an admission Minimum Data Set (MDS) dated April 17, 2012, revealed a Brief Interview for Mental Status (BIMS) score was seven (moderate mental impairment), felt down, depressed, or hopeless nearly every day, and rejected care one to three days. Continued review revealed the resident ambulated with supervision, was steady at all times with transfers and ambulation, and required limited to extensive assistance with other activities of daily living. Medical record review of a nurse's note dated	F 225	...s elopement and elopement attempts. ...n weekend and holidays the unit ...upervisor will be responsible for ...eviewing the twenty four hour report ...nd reporting the findings via a copy ...f twenty four hour report to the ...orning Quality Assurance Meeting ...n the next business day. Items that ...re identified will be reviewed for ...ompliance and results will be ...eported to the Interdisciplinary Care ...lan Team which consist of the ...Director of Nurses, MDS ...oordinators, Social Services ...irector, Environmental Services ...irector, Dietary Manager, Wound ...are Nurse and Activities Director; ...hom will also review for ...ffectiveness. All in services will be ...dded to the new employee orientation ...aining to educate new employees on ...eglect, Identification, Investigation, ...ocumentation, Patient Assessment, ...ddressing Recommendations ...imely, Notification, Elopements and ...lopement attempts.	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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F 225	Continued From page 26 April 18, 2012, at 8:00 a.m., revealed, "...wanders continuously. Wants to go home..." Medical record review of a nurse's note dated April 23, 2012, at 8:00 p.m., revealed, "...continues to pace up and down...unit aimlessly..." Medical record review of the care plan dated April 23, 2012, revealed, "Problem...Special Care Unit Placement due to increasing confusion...diminished decision abilities r/t (related to) safety Goals Will know: family, staff faces, room location Interventions Special Care Unit...Keep environment free of hazards...Assist in emergencies." Continued review revealed no intervention regarding staff supervision while in the resident's room and/or monitoring the window alarm. Medical record review of a nurse's note dated May 3, 2012, at 9:00 p.m., revealed, "...shuts...self in room and slides chair against door..." Medical record review of a nurse's note dated May 5, 2012, at 9:00 p.m. revealed, "...Puts chair under door knob per night shift..." Medical record review of a nurse's note dated May 24, 2012, at 3:00 p.m., revealed, "Severely agitated - Focused on going home...will continue to monitor." Medical record review of a nurse's note dated May 29, 2012, at 9:00 a.m., revealed, "...wandering in hallway stating 'I want to leave here I don't belong here' exit seeking...continue to monitor." Medical record review of a nurse's note dated May 31, 2012, at 10:50 p.m., revealed, "...CNAs (Certified Nursing Assistants) said (resident) had been exit-seeking earlier. Will monitor." Medical record review of a nurse's note dated	F 225	4. The Unit Supervisor will review the twenty-four hour reports on business days to ensure that elopements and elopement attempts are thoroughly investigated to ensure the safety of the resident and other residents that may be affected by the elopement attempts. The twenty- four hour report will be brought on business days to the daily Quality Assurance Meeting by the Registered Nurse Supervisor and or the Unit Supervisor. On weekend and holidays the unit supervisor will be responsible for reviewing the twenty four hour report and reporting the findings via a copy of twenty four hour report to the morning Quality Assurance Meeting on the next business day. The Director of Nurses and the Social Services Director will perform three chart reviews a week to ensure compliance is meet for three months to ensure that elopements and elopement attempts are being investigated. The findings of the reviews will be discussed in the monthly Quality Assurance Meeting for three months to ensure compliance	

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F 225	Continued From page 27 June 6, 2012, at 9:00 a.m., revealed, "...went out to patio and threatening to climb fence (fence enclosed courtyard)..." Medical record review of a nurse's note dated June 10, 2012, revealed, "(6A-6P) (6:00 a.m.-6:00 p.m.)...unable to concentrate any length of time on any one thing..." Medical record review of a nurse's note dated June 17, 2012, at 2:00 p.m., "called to resident's room screen removed from window and resident attempting to climb out redirected while staff was attempting to fix window but resident continues to attempt to leave...will cont (continue) to monitor." Medical record review of a nurse's note dated June 17, 2012, at 9:30 p.m., revealed, "Responded to CNA calling out. Went to resident's room to see CNA holding resident to keep (resident) from falling out of open window onto the ground. Resident had pushed screen out and attempted to climb out of window. This nurse was told the resident had made the same attempt earlier today...Will monitor." Interview with the DON and Administrator on July 27, 2012, at 2:20 p.m., in the DON's office, revealed the resident's attempts to elope on June 17, 2012, had not been reported. Continued interview with the DON and Administrator confirmed the facility had not investigated the attempted elopements. Medical record review of an Elopement Risk assessment dated July 3, 2012, revealed the resident had no elopement attempts in the past six months, a score of 9, and included,"Total Score: 10 or higher = (equals) at risk for elopement..." Medical record review of the care plan dated	F 225	s met. The Administrator or the Director of Nurses will lead the Quality Assurance Meeting each month to ensure that the items that are being reviewed are effective and to identify any additional areas of concerns that may be presented; or as a result of the Quality Assurance Meeting going forward.	

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F 225	Continued From page 28 April 23, 2012, revealed, "Plan of Care Comments..7-3-12...Comprehensive care plan reviewed and updated...with IDT (Interdisciplinary Team) for...quarterly CP (care plan) meeting..." Continued review revealed no revision of the care plan regarding the resident's recurrent elopement attempts. Medical record review of a nurse's note dated July 6, 2012, at 8:00 a.m., revealed, "...wandering in hallway Asking repetively (repetitive) questions about going home...will monitor." Medical record review of a nurse's note dated July 11, 2012, at 2:00 p.m., revealed, "Resident with agitation exit seeking attempted to follow (name) off the floor...redirection unsuccessful...will cont to monitor." Medical record review of a nurse's note dated July 13, 2012, at 5:35 p.m., revealed, "Resident hollering that (resident) wanted to (go) home, that we have no right to keep...against (resident's) will...Going outside in enclosed area and attempting to climb fence...one on one monitoring in process..." Interview with the Director of Nursing (DON) on July 30, 2012, at 12:15 p.m., in a conference room, revealed the DON was unaware of the initiation of one on one supervision on July 13, 2012, and unable to determine the duration of the one on one supervision. Medical record review of a nurse's note dated July 14, 2012, revealed, "@ (at) 1 pm (1:00 p.m.) window alarm sounding resident with one leg out window redirected back in window...Helped resident to bed covered with blanket and exited	F 225		

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F 225	Continued From page 29 room." Medical record review of a nurse's note dated July 14, 2012, at 1:30 p.m., revealed, "resident continuing to attempt to climb out window...RN (Registered Nurse) notified of situation...will continue to monitor." Interview with the DON and Administrator on July 27, 2012, at 2:20 p.m., in the DON's office, confirmed the attempted elopement had not been reported or investigated. Medical record review of a nurse's note dated July 16, 2012, at 9:00 a.m., revealed, "...wandering...exit seeking shaking door to leave...will cont to monitor." Medical record review of a nurse's note dated July 17, 2012, at 9:00 a.m., revealed, "...continuously asking...when am I going home...will cont (continue) to monitor." Medical record review of a nurse's note dated July 17, 2012, at 6:15 p.m., revealed, "...Exit seeking, trying to remove screen in window and climb over fence on patio. Unable to redirect..." Medical record review of a nurse's note dated July 19, 2012, at 2:30 p.m., revealed, "...Rett, (resident) crying today...wanted to go home. At one time ...yelled...and ran out back door...Will cont. to monitor behavior and attempt to redirect." Medical record review of a nurse's note dated July 19, 2012, at 7:40 p.m., revealed, "(name CNA) (#2) came running over to South Station where I was on a med (medication) cart...said (resident) was out side, over at apartment complex...(CNA #1) was on lunch and came driving back to nursing home and seen (resident) running up the road to apartment complex...saw	F 225		

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F 226	Continued From page 30 (resident) go into apartment #124...the police came and helped get (resident) back to (secure unit)..." Review of a Notification of Unusual Occurrence Check List revealed, "...Date of Occurrence : 7/19/2012 Time: 8 p.m. Location: (the room the resident exited had a line drawn through it and the room the resident was moved to after the elopement was identified)...Original care plan updated with NEW INTERVENTIONS: Yes...New Interventions one on one sitter...moved to room (another room on opposite hallway and where window exits to enclosed courtyard)...Was the facility's policy implemented at all times? Yes...Supervisors Comments: Upon investigation it was found...resident pushed the window in (resident's) room open and screen out and went out window across the street to the apartments next door, about 50-75 yards...back within 10-15 mins (minutes)..." Review of a Post Fall Review Form dated July 19, 2012, revealed, "Date of Fall..." Continued review revealed the word "fall" had a line drawn through it, and included, "Location of fall Resident's room went out window...Patient opens window in room and slopes from facility. Window alarm inaudible from hallway with door to room closed...Interdisciplinary Team Review/Recommendations...Ensure Alarm on Window Working...Resident was out of facility approximately 10-15 mins (estimate) ...Approximate Distance 50-75 ft (feet)." Continued review revealed the form was not dated or signed. Review of the facility investigation and a	F 226		

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F 225	Continued From page 31 statement by Registered Nurse (RN #1) dated July 19, 2012, revealed, "I...was working the med cart on South Station, about 8 pm (p.m.)...CNA came running...told me (resident) was out side over at apartment complex...I ran over to Greenbriar (secure unit) to see if it was really (resident), when I went into Greenbriar... (Licensed Practical Nurse) (LPN) #1 was doing...med cart, (LPN #1) did not know that (resident) was gone. I went to dinning (dining) room no (resident) , I ran down the hall to (resident's) room, the door was shut, I could not hear the alarm, I opened the door and I could hear the alarm but it was not very loud, the window was open...(resident) was gone. I ran to the apartment complex next door the police was bring (bringing) (resident) back to the nursing home in (police) car..." Review of the facility investigation and a statement by LPN #1 dated July 19, 2012, revealed, "...at approximately 0740 pm-800 pm (7:40 p.m.-8:00 p.m.) I was in the process of self-orienting myself to e-charting and the e-mar (electronic charting and electronic Medication Administration Record)...at the desk...(RN #1) enters the unit and says...has been told a resident has eloped from the unit. I...was unaware of this...and we both proceeded rapidly to (resident's) room...An alarm, which was inaudible standing immediately outside the closed door, was sounding...(resident) was returned to the unit by a law enforcement officer..." Review of the facility investigation and a statement by Certified Nursing Assistant (CNA #1) dated July 19, 2012, revealed, "While I was out on my lunch break I noticed (resident) running	F 225		

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F 225	Continued From page 32 around in the yards over at the fairgrounds (an apartment complex). I asked if I could give...a ride back (resident) hit me 3 times. That's when I realized it was going to take more than me to get (resident) back...(CNA #2) was at the front door...to let some family members out...The family members followed us over and asked what (resident) looked like...They told me to get in with them and they would drive me around to see if I could find (resident). I happened to see a man across the street pointing towards an apartment...the woman that was with us said I'm a nurse let me take care of this. She knocked on the door and said she was calling the law. Her husband called 911. The cops showed up and (RN #1) and (Maintenance Director) was walking over...the cop took (resident) over to the nursing home..." Review of the facility investigation dated July 25, 2012, revealed, "...Date of Alleged Event: 07/19/2012...was in own room, opened the window, and crawled out of window (resident)...running down the road ...Resident had just left the facility when seen by the CNA in the fair grounds (apartment complex) no more than 15 minutes...The LPN and the CNAs did not hear the alarm going off in the room due to the door was shut..." Interview with CNA #1 on July 27, 2012, at 1:45 p.m., in a conference room, revealed CNA #1 had left the facility for lunch at approximately 7:00 p.m. and on returning from lunch observed the resident out of the facility. Continued interview revealed the resident was on the far side of the second street from the facility (not the location identified in the facility's investigation), and CNA	F 225		

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F 225	Continued From page 33 #1 stated, "...I noticed (resident) right there on the side of the road straight across the street from (the) apartment where (resident) was at...hit me two to three times right up the side of the head...decided I needed more help...I got to the road to turn in here, looked back and saw (resident) running toward that apartment. Saw (resident) go up the steps...That shocked me that (resident) was that far and nobody noticed.." Telephone interview with local Law Enforcement Officer #1 on July 30, 2012, at 9:45 a.m., revealed an officer responded to a complaint call on July 19, 2012, at 7:37 p.m. regarding a facility resident. Continued interview confirmed an officer returned the resident to the facility and the complaint call was completed at 8:13 p.m. Interview with the DON and the Administrator on July 27, 2012, at 2:20 p.m., in the DON's office, revealed no knowledge regarding the resident's attempts to elope two times on June 17, 2012. Continued interview revealed the DON had reviewed the twenty-four hour communication book and spoken with nursing managers. The DON stated, "...all say they were unaware of previous attempts to elope..." Continued interview revealed no reports of elopement attempts had been made and the facility had no investigations into the resident's attempts to elope prior to July 19, 2012. Continued interview confirmed the facility failed to investigate recurrent elopement attempts for Resident #3, placing Resident #3 in Immediate Jeopardy. Corrective actions which removed the immediacy of the jeopardy, included one on one supervision of the resident while installation of additional	F 225		

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	445259	A. BUILDING _____ B. WING _____	C 07/30/2012

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F 225	Continued From page 34 alarms to the windows on the secure unit was completed, assessment and care plan revision for the resident and other resident's at risk, and revision of policies and procedures and staff education regarding identification, investigation, and notification of unusual occurrences including abuse and/or neglect. The surveyor verified the corrective actions on July 30, 2012, by observation, medical record review, policy review, and interview. Non-compliance continues at a "D" level for monitoring corrective actions through the facility's Quality Assurance/Performance Improvement Program. The facility is required to submit a plan of correction. Refer to F157 J. Refer to F224-J-Substandard Quality of Care. C/O: #30197	F 225		
F 250 SS=J	483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interview, the facility failed to provide required social services to prevent elopement for one resident (#3) with identified elopement risk	F 250	Requirement: The facility will provide medically-related social services to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident.	8/17/2012

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 250	Continued From page 35 behaviors of seven sampled residents. The facility's failure to provide required Social Services to prevent elopement for Resident #3 resulted in Immediate Jeopardy (a situation that is likely to cause serious harm, injury, impairment, or death). The Immediate Jeopardy was effective June 17, 2012, through July 24, 2012. The Administrator and Director of Nursing (DON) were notified of the Immediate Jeopardy on July 30, 2012, at 12:38 p.m., in the Administrator's office. The findings included: Resident #3 was admitted to the facility on April 10, 2012, with diagnoses including Dementia and Unspecified Bipolar Disorder. Medical record review of a hospital History and Physical dated March 25, 2012, revealed, "...admitted by neurosurgery services for subarachnoid hemorrhage...underwent aneurysm clipping...resulting in waxing mental status changes, psychosis...discharged again in stable condition on 3-21-12 ...Daughter states...increased symptoms of agitation and mental status changes...picking at things and has been talking about hurting...self...asked for sharp objects and a knife and talked about cutting...wrist...Assessment and Plan:...concerns about suicidal ideations. Suicide precautions will be initiated..." Medical record review of a nurse's note dated	F 250	Corrective Action: 3. The Social Serviced Director was in serviced on providing medically-related social services to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident, on 8/3/2012 by the Administrator. All clinical staff was also in serviced on addressing medically-related social services to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident, and the use of the twenty-four hour report to communicate issues to the social serviced director was in serviced by the Director of Nurses, the Administrator and or the Unit Supervisor by 8/14/2012. The Interdisciplinary Care Plan team which consist of the Director of Nurses, MDS Coordinators, Social Services Director , Environmental Services Director , Dietary Manager , Wound Care Nurse and Activities Director were in serviced by the Administrator by 8/14/2012 on Neglect, Identification, Investigation, Documentation, Patient Assessment, Notification; and use of the 24 hour report for communication. The	

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F 250	Continued From page 36 April 14, 2012, at 2:05 p.m., revealed the resident was admitted to a room in the facility's secure (locked) unit. Medical record review of a nurse's note dated April 14, 2012, at 11:00 p.m., revealed, "...Has episodes of exit-seeking. Will continue to monitor." Medical record review of a nurse's note dated April 18, 2012, at 8:00 a.m., revealed, "...wanders continuously. Wants to go home. States '...let me go home...these people are driving me crazy.' Will notify Social Services..." Medical record review of a nurse's note dated April 18, 2012, at 6:40 p.m., revealed, "...Resident expressed desire to be moved off of this unit..'These people back here are driving me crazy & (and) I am afraid of them.' Will leave information with (Social Service Director) for further intervention..." Medical record review of a nurse's note dated April 22, 2012, at 3:00 p.m., revealed, "...wanting to stay with staff - stating 'they will hurt me.'..." Medical record review of an admission Minimum Data Set (MDS) dated April 17, 2012, revealed a Brief Interview for Mental Status (BIMS) score was seven (moderate mental impairment), felt down, depressed, or hopeless nearly every day, and rejected care one to three days. Medical record review of the care plan dated April 23, 2012, revealed, "Problem...Mood pleasant - No behaviors noted, refused skin assessment...Notify nursing of any change in mood/behavior...Disciplines... SS (social service) Visit one: one (one staff to one resident) with resident weekly...Discipline SS..." Continued review revealed the care plan was revised by the	F 250	twenty- four hour report will be collected each day by the Unit Supervisor and reviewed to identify events that require notification. On weekend and holidays the unit supervisor will be responsible for reviewing the twenty four hour report and reporting the findings via a copy of twenty four hour report to the morning Quality Assurance Meeting on the next business day. Those items that are identified will be reviewed for compliance and results will be reported to the Interdisciplinary Care Plan Team which consist of the Director of Nurses, MDS Coordinators, Social Services Director, Environmental Services Director, Dietary Manager, Wound Care Nurse and Activities Director; which will also review for effectiveness. The Director of Nurses will review results to ensure compliance.	

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F 250	Continued From page 37 Interdisciplinary team, no documentation regarding new interventions to address the resident's behavior and included, "7-3-12...Comprehensive care plan reviewed and updated...with IDT (Interdisciplinary Team)." Medical record review of a nurse's note dated May 5, 2012, at 2:00 p.m. revealed, "...doesn't like to be alone in (resident's) room..." Medical record review of a physician's order dated May 10, 2012, revealed, "Change Haldol (antipsychotic medication) to 2 mg (milligrams) po bid (by mouth twice daily)." Medical record review of a nurse's note dated May 24, 2012, at 8:00 p.m., revealed, "Severely agitated - Focused on going home...will continue to monitor." Medical record review of a nurse's note dated May 27, 2012, at (first shift) revealed, "...at times becomes verbally threatening to other resd (residents)..." Medical record review of a nurse's note dated May 29, 2012, at 8:00 a.m., revealed, "...I want to leave here I don't belong here...exit seeking ...continue to monitor." Medical record review of a nurse's note dated June 6, 2012, at 9:00 a.m., revealed, "...went out to patio and threatening to climb fence..." Medical record review of a nurse's note dated June 10, 2012, revealed, "(6A-6P) (6:00 a.m. -6:00 p.m.)...unable to concentrate any length of time on any one thing..." Medical record review of a nurse's note dated June 17, 2012, at 2:00 p.m., "called to resident's room screen removed from window and resident attempting to climb out	F 250	4. The Social Services Director or Director of Nurses will review the twenty-four hour reports on business days to ensure that the facility is providing medically-related social services to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident. On weekends and holidays the unit supervisor will be responsible for reviewing the twenty four hour report and reporting the findings via a copy of twenty four hour report to the morning Quality Assurance Meeting or the next business day for review by the Social Services Director. The Social Services Director will also review behavior logs that were created to allow all staff, not just clinical, to report behaviors that may need to be addressed by Social Services. The Social Services Director will review three charts a week to identify any residents that need medically-related social services to attain or maintain the highest practicable physical, mental and psychosocial well-being. The Administrator or Director of Nurses will lead the Quality Assurance Meeting each month to ensure that the items that are being reviewed are effective and to identify	

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F 260	Continued From page 38 redirected while staff was attempting to fix window but resident continues to attempt to leave...will cont (continue) to monitor." Medical record review of a nurse's note dated June 17, 2012, at 9:30 p.m., revealed, "Responded to CNA (Certified Nursing Assistant) calling out. Went to resident's room to see CNA holding resident to keep (resident) from falling out of open window onto the ground. Resident had pushed screen out and attempted to climb out of window. This nurse was told the resident had made the same attempt earlier today...Will monitor." Medical record review of a physician's order dated June 18, 2012, at 8:00 a.m., revealed, "Family intervention meeting 6-18-12 @ (at) 2 pm." Medical record review revealed no documentation regarding a family intervention meeting. Medical record review of a Nurse Practitioner Progress note dated June 19, 2012, revealed, "...Nursing staff notified of increased agitation...appears extremely agitated and has delusions, combative...Schizoaffective disorder ..." Medical record review of a Psychotropic Medication Evaluation dated July 4, 2012, at 12:01 p.m., revealed, "...Mood/Affect...Dysphoric Severity 6...Flat Severity 7 (1 = Least Severe, 10 = (equals) Most Severe)..." Continued review revealed, "...presents with severe insomnia...staff reported episodic mood swings...some inc (increased) delusions...Rationale for Recommendations...also may increase haldol 2 mg 1/2 tab (tablet) afternoon in addition to bid dose pm (as needed)..." Continued review	F 260	any additional areas of concerns that may be presented or as a result of the Quality Assurance Meeting going forward.	

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F 250	Continued From page 39 revealed the recommendations were approved by a nurse practitoner on July 20, 2012. Medical record review of a nurse's note dated July 6, 2012, at 8:00 a.m., revealed, "...wandering in hallway Asking repatively (repetitive) questions about going home...will monitor." Medical record review of a nurse's note dated July 11, 2012, at 2:00 p.m., revealed, "Resident with agitation exit seeking attempted to follow (name) off the floor...redirection unsuccessful...will cont to monitor." Medical record review of a Psychotropic Medication Management Progress Note dated July 13, 2012, at 12:45 p.m., revealed, "...appeared vigilant and peranoid. Staff reported...has been crazy...staff reported inc (increased) paranoia as dementia escalates. Current c/o (complaint) inc (include) physical aggression and irritability. Plan: increase haldol 2 mg. tid (three times daily)...Indications for next visit: Acute Behavioral/Medical Problem...Delusions...Judgment Impaired...Ambulatory ...SI/HI (suicidal/homicidal ideation) Unable to assess due to patient's cognitive impairment...Behavior interventions not indicated in patient record." Continued review revealed the Progress Note was not reviewed by a physician or a nurse practitioner until July 23, 2012 (ten days later) and included, "...Accept..." Medical record review of a physician's order dated July 23, 2012, revealed, "Haldol 1 mg @ noon." Medical record review of a nurse's note dated July 13, 2012, at 5:35 p.m., revealed, "Resident	F 250		

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F 250	Continued From page 40 hollering that (resident) wanted to (go) home, that we have no right to keep...against (resident's) will...Going outside in enclosed area and attempting to climb fence..." Medical record review of a nurse's note dated July 14, 2012, revealed, "@ 1 pm (1:00 p.m.) window alarm sounding resident with one leg out window redirected back in window...Helped resident to bed covered with blanket and exited room." Medical record review of a nurse's note dated July 14, 2012, at 1:30 p.m., revealed, "resident continuing to attempt to climb out window...RN (Registered Nurse) notified of situation...will continue to monitor." Medical record review of a nurse's note dated July 16, 2012, at 9:00 a.m., revealed, "...wandering...exit seeking shaking door to leave...will cont to monitor." Medical record review of a nurse's note dated July 17, 2012, at 9:00 a.m., revealed, "...continuously asking...when am I going home...will cont to monitor." Medical record review of a nurse's note dated July 17, 2012, at 6:15 p.m., revealed, "...Exit seeking, trying to remove screen in window and climb over fence on patio. Unable to redirect..." Medical record review of a nurse's note dated July 19, 2012, at 2:30 p.m., revealed, "...Res. (resident) crying today...wanted to go home. At one time ...yelled...and ran out back door...Will cont. to monitor behavior and attempt to redirect." Medical record review of a nurse's note dated July 19, 2012, at 7:40 p.m., revealed, "(CNA #2) came running over to South Station where I was on a med (medication) cart...said (resident) was out side, over at apartment complex ...(CNA #1) was on lunch and came driving back to nursing	F 250		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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PRINTED: 08/08/2012
FORM APPROVED
OMB NO. 0938-0391

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SUMMIT VIEW OF LAKE CITY, LLC	2141 INDUSTRIAL PARK RD LAKE CITY, TN 37769

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F 250	Continued From page 41 home and seen (resident) running up the road to apartment complex...saw (resident) go into apartment #124...the police came and helped get (resident) back to (secure unit)..." Medical record review of the Medication Administration Record dated July 2012 revealed the resident was administered Haldol 2 mg. at 8:00 a.m. and 8:00 p.m. from July 1, 2012, through July 23, 2012. Continued review revealed administration of Haldol 1 mg. at 12:00 p.m., was not initiated until July 24, 2012 (twenty days following the first recommendation of July 4, 2012). Observation on July 26, 2012, at 3:02 p.m., revealed the resident ambulated to the nurse's station and stated, "I wanna (want to) go home, I love you. Can I go home with you?" Interview with the Social Service Director (SSD) on July 27, 2012, at 3:17 p.m., in a conference room, revealed the physician ordered a family meeting scheduled for June 18, 2012, the meeting did not occur, and the SSD stated, "...don't know the purpose of the meeting..." Interview with the SSD on July 30, 2012, at 11:00 a.m., in a conference room, revealed the resident's risk for elopement was discussed in a care plan meeting on July 3, 2012, and the resident's recurrent attempts to elope were not discussed. Continued interview revealed in response to inquiry regarding a behavior plan for the resident, the SSD stated, "Certain things we expect from a resident who's on (secure unit). Have a minister that we can call in if we want... (Resident) doesn't like anyone to come to	F 250		

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F 250	Continued From page 42 (resident's) door...Couldn't figure out why (resident) was afraid of a particular resident. (I) visit every unit weekly...no behavior plan for (resident)..." Continued interview revealed the SSD provided more frequent one on one visits with the resident and diversional activies after the resident eloped. Continued interview revealed the SSD was uncertain if the resident was currently treated by a mental health provider and confirmed the facility failed to provide social services to attain the highest practicable mental and psychosocial well-being for Resident #3, resulting in elopement and placing Resident #3 in immediate Jeopardy. Corrective actions which removed the immediacy of the jeopardy, included one on one supervision of the resident while installation of additional alarms to the windows on the secure unit was completed, assessment and care plan revision for the resident and other resident's at risk, revision of policies and procedures, and staff education regarding identification, investigation, and notification of unusual occurrences including abuse and/or neglect, increased frequency of routine one on one visits by the SSD and on request of secure unit staff. The surveyor verified the corrective actions on July 30, 2012, by observation, medical record review, policy review, and interview. Non-compliance continues at a "D" level for monitoring corrective actions through the facility's Quality Assurance/Performance Improvement Program. The facility is required to submit a plan of correction.	F 250		

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F 250	Continued From page 43 Refer to F157-J. Refer to F224-J, Substandard Quality of Care. Refer to F225-J, Substandard Quality of Care. C/O: #30197	F 250		
F 272 SS=J	483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and	F 272	Requirement: The facility will conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. Corrective Action: 3. Care plans will be assessed, re assessed and updated as changes in patient status are identified The Director of Nurses, The Social Services Director and the MDS Coordinator will review three charts a week that are identified in the facilities high risk meeting to identify any residents that needs to be re-assessed. The patients will be re assessed in the high risk meeting and the patients care plan will be updated to reflect the resident's plan of care. These changes include but are not limited to the care plan, the MDS assessment, and the Social Services Progress Notes. The Director of Nurses will review results to ensure compliance is met	8/17/2012

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F 272	Continued From page 44 Documentation of participation in assessment. This REQUIREMENT is not met as evidenced by: Based on medical record review and interview, the facility failed to re-assess one resident with recurrent unsafe behaviors (#3) of seven sampled residents. The facility's failure to re-assess the recurrent unsafe behaviors of Resident #3 resulted in an actual elopement and Immediate Jeopardy (a situation that is likely to cause serious harm, injury, impairment, or death). The Immediate Jeopardy was effective June 17, 2012, through July 24, 2012. The Administrator and Director of Nursing (DON) were notified of the Immediate Jeopardy on July 30, 2012, at 12:38 p.m., in the Administrator's office. The findings included: Resident #3 was admitted to the facility on April 10, 2012, with diagnoses including Dementia and Unspecified Bipolar Disorder. Medical record review of a hospital History and Physical dated March 25, 2012, revealed,	F 272	... Audits that are performed during the month by the Director of Nurses, the MDS coordinators, and the Social Services Director will be collected and presented at the monthly Quality Assurance Meeting for review by The Interdisciplinary Care Plan Team which consist of the Director of Nurses, MDS Coordinators, Social Services Director, Environmental Services Director, Dietary Manager, Wound Care Nurse, Activities Director and the Medical Director. The Director of Nurses, the MDS Coordinators, and the Social Services Director will conduct three chart reviews weekly to identify that a comprehensive assessment has been conducted on the identified residents. The Administrator or Director of Nurses will lead the Quality Assurance Meeting each month to ensure that the items that are identified are updated in the resident's plan of care, and are being re assessed to reflect the most up to date plan of care. The Administrator or Director of Nurses will lead the Quality Assurance Meeting each month to ensure that the items that are being reviewed are effective and to identify	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 272	Continued From page 45 "...admitted by neurosurgery services for subarachnoid hemorrhage...underwent aneurysm clipping...resulting in waxing mental status changes, psychosis...discharged again in stable condition on 3-21-12...Daughter states...increased symptoms of agitation and mental status changes...picking at things and has been talking about hurting...self...asked for sharp objects and a knife and talked about cutting...wrist...Assessment and Plan:...concerns about suicidal ideations. Suicide precautions will be initiated..." Medical record review of an undated Elopement Risk Form revealed a score of 10 and included, "...Total Score: 10 or Higher = (equals) At risk for elopement ...Placed on Greenbriar (secure) unit for increased Elopement Risk..." Medical record review of a nurse's note dated April 14, 2012, at 2:05 p.m., revealed the resident was admitted to a room in the facility's secure unit and included, "...confused, ambulates with steady gait..." Medical record review of a nurse's note dated April 14, 2012, at 11:00 p.m., revealed, "...Has episodes of exit-seeking. Will continue to monitor." Medical record review of an admission Minimum Data Set (MDS) dated April 17, 2012, revealed a Brief Interview for Mental Status (BIMS) score was seven (moderate mental impairment), felt down, depressed, or hopeless nearly every day, and rejected care one to three days. Continued review revealed the resident ambulated with supervision, was steady at all times with transfers	F 272	...ny additional areas of concerns that ...ay be presented or as a result of the ...uality Assurance Meeting going ...orward.	

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SUMMIT VIEW OF LAKE CITY, LLC	2 M INDUSTRIAL PARK RD LAKE CITY, TN 37769

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F 272	Continued From page 46 and ambulation, and required limited to extensive assistance with other activities of daily living. Medical record review of a nurse's note dated April 18, 2012, at 8:00 a.m., revealed, "...wanders continuously. Wants to go home..." Medical record review of a nurse's note dated April 23, 2012, at 8:00 p.m., revealed, "...continues to pace up and down...unit aimlessly..." Medical record review of a nurse's note dated May 3, 2012, at 9:00 p.m., revealed, "...shuts...self in room and slides chair against door..." Medical record review of a nurse's note dated May 5, 2012, at 3:00 p.m. revealed, "...Puts chair under door knob per night shift..." Medical record review of a nurse's note dated May 24, 2012, at 3:00 p.m., revealed, "Severely agitated - Focused on going home...will continue to monitor." Medical record review of a nurse's note dated May 29, 2012, at 9:00 a.m., revealed, "...wandering in hallway stating 'I want to leave here I don't belong here' exit seeking ...continue to monitor." Medical record review of a nurse's note dated May 31, 2012, at 10:50 p.m., revealed, "...CNAs (Certified Nursing Assistants) said (resident) had been exit-seeking earlier. Will monitor." Medical record review of a nurse's note dated June 6, 2012, at 9:00 a.m., revealed, "...went out to patio and threatening to climb fence..." Medical record review of a nurse's note dated June 10, 2012, revealed, "(6A-6P) (6:00 a.m. -6:00 p.m.)...unable to concentrate any length of time on any one thing..." Medical record review of a nurse's note dated June 17, 2012, at 2:00 p.m., "called to resident's room screen removed	F 272		

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F 272	Continued From page 47 from window and resident attempting to climb out redirected while staff was attempting to fix window but resident continues to attempt to leave...will cont (continue) to monitor." Medical record review of a nurse's note dated June 17, 2012, at 9:30 p.m., revealed, "Responded to CNA calling out. Went to resident's room to see CNA holding resident to keep (resident) from falling out of open window onto the ground. Resident had pushed screen out and attempted to climb out of window. This nurse was told the resident had made the same attempt earlier today...Will monitor." Medical record review of a Nurse Practitioner's (NP) Progress note dated June 19, 2012, revealed, "...Nursing staff notified of increased agitation...appears extremely agitated and has delusions, combative...Schizoaffective disorder..." Medical record review of a nurse's note dated June 19, 2012, at 9:00 p.m., revealed, "...Trying to climb fence at patio. Unable to redirect..." Medical record review of an Elopement Risk assessment dated July 3, 2012, revealed the resident had gone more than 120 days without an elopement attempt, a score of 9, and included,"Total Score: 10 or higher = (equals) at risk for elopement..." Medical record review of a nurse's note dated July 6, 2012, at 8:00 a.m., revealed, "...wandering in hallway Asking repetively (repetitive) questions about going home...will monitor." Medical record review of a nurse's note dated July 11, 2012, at 2:00 p.m., revealed, "Resident with agitation exit seeking attempted to follow (name) off the	F 272		

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F 272	Continued From page 48 floor...redirection unsuccessful...will cont to monitor." Medical record review of a Psychotropic Medication Evaluation dated July 4, 2012, at 12:01 p.m., revealed, "...presents with severe insomnia...staff reported episodic mood swings...some inc (increased) delusions..." Medical record review of a Psychotropic Medication Management Progress Note dated July 13, 2012, at 12:45 p.m., revealed, "...appeared vigilant and paranoid. Staff reported...has been crazy...staff reported inc paranoia as dementia escalates. Current c/o (complaint) inc (include) physical aggression and irritability...." Medical record review of a nurse's note dated July 14, 2012, revealed, "@ (at) 1 pm (1:00 p.m.) window alarm sounding resident with one leg out window redirected back in window...Helped resident to bed covered with blanket and exited room." Medical record review of a nurse's note dated July 14, 2012, at 1:30 p.m., revealed, "resident continuing to attempt to climb out window...RN (Registered Nurse) notified of situation...will continue to monitor." Medical record review of a nurse's note dated July 16, 2012, at 9:00 a.m., revealed, "...wandering...exit seeking shaking door to leave...will cont to monitor." Medical record review of a nurse's note dated July 17, 2012, at 9:00 a.m., revealed, "...continuously asking...when am I going home...will cont to monitor." Medical record review of a nurse's note dated July 17, 2012, at 6:15 p.m., revealed, "...Exit seeking, trying to remove screen in window and climb over fence	F 272		

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F 272	Continued From page 49 on patio. Unable to redirect..." Medical record review of a nurse's note dated July 19, 2012, at 2:30 p.m., revealed, "...Res. (resident) crying today...wanted to go home. At one time ...yelled...and ran out back door...Will cont. to monitor behavior and attempt to redirect." Medical record review of a nurse's note dated July 19, 2012, at 7:40 p.m., revealed, "(CNA #2) came running over to South Station where I was on a med (medication) cart...said (resident) was out side, over at apartment complex ...(CNA #1) was on lunch and came driving back to nursing home and seen (resident) running up the road to apartment complex...saw (resident) go into apartment #124...the police came and helped get (resident) back to (secure unit)..." Medical record review of an Elopement Risk Form dated July 19, 2012, completed by the Licensed Practical Nurse on duty at the time of the resident's elopement, revealed a score of twelve and included, "...2 or more attempts...Total Score: 10 or Higher = (equals) At risk for elopement..." Interview with MDS Coordinator #3 on July 27, 2012, revealed MDS Coordinator #3 was unaware the resident had attempted elopement prior to the elopement on July 19, 2012. Interview with the Social Service Director (SSD) on July 30, 2012, at 11:00 a.m., revealed the interdisciplinary team reviewed the resident's risk for elopement on July 3, 2012. The SSD stated, "...We talked about (resident) wanting to go home, the risk for elopement was discussed but not elopement attempts..."	F 272		

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F 272	Continued From page 50 Interview with NP #2 on July 30, 2012, at 12:00 p.m., in a conference room, revealed NP #2 had reviewed the resident's mental health assessment documentation, did not understand it, and failed to clarify the assessment data. Interview with Registered Nurse (RN) #2 on July 30, 2012, at approximately 4:00 p.m., revealed RN #2 completed the elopement risk assessment dated July 3, 2012. RN #2 stated related to the incorrect assessment that documented the resident had not eloped in the last 120 days, "The assessment is incorrect. I did it. It's solely my responsibility." Interview with the DON on July 30, 2012, at approximately 4:15 p.m., in the DON's office, confirmed the facility failed to reassess Resident #3. The DON stated, "...missed every opportunity..." Corrective actions which removed the immediacy of the jeopardy, included one on one supervision of the resident while installation of additional alarms to the windows on the secure unit was completed, assessment and care plan revision for the resident and other resident's at risk, revision of policies and procedures regarding identification, investigation, and notification of unusual occurrences including abuse and/or neglect and staff education. The surveyor verified the corrective actions on July 30, 2012, by observation, medical record review, policy review, and interview. Non-compliance continues at a "D" level for	F 272		

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F 272	Continued From page 51 monitoring corrective actions through the facility's Quality Assurance/Performance Improvement Program. The facility is required to submit a plan of correction. Refer to F157-J. Refer to F224-J, Substandard Quality of Care. Refer to F225-J, Substandard Quality of Care. Refer to F250-J, Substandard Quality of Care. C/O: #30197	F 272		
F 280 SS=J	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by:	F 280	Requirement: The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan will be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and	8/17/2012

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F 280	Continued From page 52 Based on medical record review, review of facility investigation, observation, and interview, the facility failed to revise the care plan to address recurrent unsafe behaviors for one resident (#3) of seven sampled residents. The facility's failure to revise the care plan to address recurrent recurrent unsafe behaviors of Resident #3 resulted in an actual elopment and Immediate Jeopardy (a situation that is likely to cause serious harm, injury, impairment, or death). The Immedidate Jeopardy was effective on June 17, 2012, through July 24, 2012. The Administrator and Director of Nursing (DON) were notified of the Immediate Jeopardy on July 30, 2012, at 12:38 p.m. in the Administrator's office. The findings included: Resident #3 was admitted to the facility on April 10, 2012, with diagnoses including Dementia and Unspecified Bipolar Disorder. Medical record review of a hospital History and Physical dated March 26, 2012, revealed, "...admitted by neurosurgery services for subarachnoid hemorrhage...underwent aneurysm clipping...resulting in waxing mental status changes, psychosis...discharged again in stable condition on 3-21-12 ...Daughter states...increased symptoms of agitation and mental status changes...picking at things and has been talking about hurting...self...asked for sharp objects and a knife and talked about cutting...wrist...Assessment and Plan:...concerns	F 280	periodically reviewed and revised by a team of qualified persons after each assessment. Corrective Action: 1. The Interdisciplinary Care Plan team which consist of the Director of Nurses, MDS Coordinators, Social Services Director , Environmental Services Director , Dietary Manager , Wound Care Nurse and Activities Director were all in serviced on the residents right to participate in their care planning activities. All residents will be offered the opportunity to be involved with their Plan of Care by the Social Serviced Director going forward. A Care Plan meeting was conducted with Resident #3 and the husband was contacted so that he could also participate in the plan of care as her responsible party. Care plans will be updated as changes in patient status are identified by the MDS assessment and by the inter-disciplinary care plan teams assessments. The Director of Nurses, The Social Services Director and the MDS Coordinators will review three charts a weekly and the findings of these reviews will be addressed then	

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F 280	Continued From page 53 about suicidal ideations. Suicide precautions will be initiated..." Medical record review of an admission Minimum Data Set (MDS) dated April 17, 2012, revealed a Brief Interview for Mental Status (BIMS) score was seven (moderate mental impairment), felt down, depressed, or hopeless nearly every day, and rejected care one to three days. Medical record review of a nurse's note dated April 14, 2012, at 11:00 p.m., revealed, "...Has episodes of exit-seeking. Will continue to monitor." Medical record review of a nurse's note dated April 18, 2012, at 8:00 a.m., revealed, "...wanders continuously. Wants to go home..." Medical record review of the care plan dated April 23, 2012, revealed, "Problem...Special Care Unit Placement due to increasing confusion...diminished decision abilities r/t (related to) safety Goals Will know: family, staff faces, room location Interventions Special Care Unit :..Keep environment free of hazards...Assist in emergencies..." Medical record review of a nurse's note dated April 23, 2012, at 8:00 p.m., revealed, "...continues to pace up and down...unit aimlessly..." Medical record review of a nurse's note dated May 3, 2012, at 9:00 p.m., revealed, "...shuts...self in room and slides chair against door..." Medical record review of a nurse's note dated May 5, 2012, at 3:00 p.m. revealed, "...Puts chair under door knob per night shift.." Medical record review of a nurse's note dated May 24,	F 280	reviewed in the monthly Quality Assurance Meeting to identify any residents that need to be assessed or re assessed. Also residents that have changes that are identified during the MDS assessment, those changes will be reported to and addressed by the interdisciplinary care plan team in the high risk meeting weekly so the residents care plan can be revised to reflect the resident's current plan of care. The Director of Nurses will review results to ensure compliance. 4. Audits that are performed during the month by the Director of Nurses, the MDS coordinators, and the Social Services Director will be collected and presented at the monthly Quality Assurance Meeting for review by The Interdisciplinary Care Plan Team which consist of the Director of Nurses, MDS Coordinators, Social Services Director, Environmental Services Director, Dietary Manager, Wound Care Nurse, Activities Director, Administrator and the Medical Director. The Administrator or Director of Nurses will lead the Quality Assurance Meeting each month to ensure that the items that are identified are updated in the resident's plans of care, and are being assessed	

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F 280	Continued From page 54 2012, at 3:00 p.m., revealed, "Severely agitated - Focused on going home...will continue to monitor." Medical record review of a nurse's note dated May 29, 2012, at 9:00 a.m., revealed, "...wandering in hallway stating 'I want to leave here I don't belong here' exit seeking ...continue to monitor." Medical record review of a nurse's note dated May 31, 2012, at 10:50 p.m., revealed, "...CNAs (Certified Nursing Assistants) said (resident) had been exit-seeking earlier. Will monitor." Medical record review of a nurse's note dated June 6, 2012, at 9:00 a.m., revealed, "...went out to patio and threatening to climb fence..." Medical record review of a nurse's note dated June 10, 2012, revealed, "(6A-6P) (6:00 a.m. -6:00 p.m.)...unable to concentrate any length of time on any one thing..." Medical record review of a nurse's note dated June 17, 2012, at 2:00 p.m., "called to resident's room screen removed from window and resident attempting to climb out redirected while staff was attempting to fix window but resident continues to attempt to leave...will cont (continue) to monitor." Medical record review of a nurse's note dated June 17, 2012, at 8:30 p.m., revealed, "Responded to CNA calling out. Went to resident's room to see CNA holding resident to keep (resident) from falling out of open window onto the ground. Resident had pushed screen out and attempted to climb out of window. This nurse was told the resident had made the same attempt earlier today...Will monitor." Medical record review of a nurse's note dated July 11, 2012, at 2:00 p.m., revealed, "Resident with agitation exit seeking attempted to follow	F 280	and re assessed to reflect the most up to date resident condition.	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 280	Continued From page 55 (name) off the floor...redirection unsuccessful...will cont to monitor." Medical record review of a nurse's note dated July 13, 2012, at 5:35 p.m., revealed, "Resident hollering that (resident) wanted to (go) home, that we have no right to keep...against (resident's) will...Going outside in enclosed area and attempting to climb fence..." Medical record review of a nurse's note dated July 14, 2012, revealed, "@ (at) 1 pm (1:00 p.m.) window alarm sounding resident with one leg out window redirected back in window ...Helped resident to bed covered with blanket and exited room." Medical record review of a nurse's note dated July 14, 2012, at 1:30 p.m., revealed, "resident continuing to attempt to climb out window...RN (Registered Nurse) notified of situation...will continue to monitor." Medical record review of a nurse's note dated July 16, 2012, at 9:00 a.m., revealed, "...wandering...exit seeking shaking door to leave...will cont to monitor." Medical record review of a nurse's note dated July 17, 2012, at 9:00 a.m., revealed, "...continuously asking...When am I going home ...will cont to monitor." Medical record review of a nurse's note dated July 17, 2012, at 6:15 p.m., revealed, "...Exit seeking, trying to remove screen in window and climb over fence on patio. Unable to redirect..." Medical record review of a nurse's note dated July 19, 2012, at 2:30 p.m., revealed, "...Res. (resident) crying today...wanted to go home. At one time ...yelled...and ran out back door...Will cont. to monitor behavior and attempt to redirect." Medical record review of a nurse's note dated	F 280		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/03/2012
FORM APPROVED
OMB NO. 0938-0391

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F 280	Continued From page 56 July 19, 2012, at 7:40 p.m., revealed, "(CNA #2) came running over to South Station where I was on a med (medication) cart...said (resident) was out side, over at apartment complex...(CNA #1) was on lunch and came driving back to nursing home and seen (resident) running up the road to apartment complex...saw (resident) go into apartment #124...the police came and helped get (resident) back to (secure unit)..." Review of a Notification of Unusual Occurrence Check List revealed, "...Date of Occurrence : 7/19/2012 Time: 8 p.m. Location: (the room the resident exited had a line drawn through it and the room the resident was moved to after the elopement was identified) ...Original care plan updated with NEW INTERVENTIONS: Yes..." Review of the original care plan revealed it had been updated but had not been updated with interventions related to attempts to elope and/or actual elopements. Observation on July 28, 2012, at 3:02 p.m., revealed the resident ambulated to the nurse's station and stated, "I wanna (want to) go home. I love you. Can I go home with you?" Medical record review of the resident's care plan and interview with MDS Coordinator #1 on July 27, 2012, at 2:05 p.m., in a conference room, revealed the care plan was the resident's current care plan. Continued interview confirmed the facility failed to revise the resident's care plan to address the resident's recurrent attempts to elope and/or actual elopement. Corrective actions which removed the immediacy of the jeopardy, included one on one supervision	F 280		

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SUMMIT VIEW OF LAKE CITY, LLC	200 INDUSTRIAL PARK RD LAKE CITY, TN 37769

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F 280	Continued From page 57 of the resident while installation of additional alarms to the windows on the secure unit was completed, assessment and care plan revision for the resident and other resident's at risk, revision of policies and procedures regarding identification, investigation, and notification of unusual occurrences and/or neglect and staff education. The surveyor verified the corrective actions on July 30, 2012, by observation, medical record review, policy review, and interview. Non-compliance continues at a "D" level for monitoring corrective actions through the facility's Quality Assurance/Performance Improvement Program. The facility is required to submit a plan of correction. Refer to F157-J. Refer to F224-J, Substandard Quality of Care. Refer to F225-J, Substandard Quality of Care. Refer to F250-J, Substandard Quality of Care. Refer to F272-J.	F 280		
F 309 SS=J	C/O: #30197 483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.	F 309	Requirement: Each resident will receive and the facility will provide the necessary care and services to attain or maintain the highest practicable physical, mental and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.	8/17/2012

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	445269	A. BUILDING _____ B. WING _____	C 07/30/2012

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F 309	Continued From page 58 This REQUIREMENT is not met as evidenced by: Based on medical record review and interview, the facility failed to timely communicate recommendations for a change in an antipsychotic medication for one resident (#3) with recurrent unsafe behaviors of seven sampled residents. The facility's failure to ensure a change in an antipsychotic medication for recurrent unsafe behaviors was started timely for Resident #3 resulted in Immediate Jeopardy (a situation that is likely to cause serious harm, injury, impairment, or death). The Immediate Jeopardy was effective on June 17, 2012, through July 24, 2012. The Administrator and Director of Nursing (DON) were notified of the Immediate Jeopardy on July 30, 2012, at 12:38 p.m., in the Administrator's office. The findings included: Resident #3 was admitted to the facility on April 10, 2012, with diagnoses including Dementia and Unspecified Bipolar Disorder. Medical record review of a physician's order dated April 11, 2012, revealed, "Haldol 1 mg (milligrams) 3 tabs bid (an antipsychotic medication one milligram three tablets twice daily)." Medical record review of a physician's order dated May 10, 2012, revealed, "Change Haldol to 2 mg. po (by mouth) bid."	F 309	Corrective Action: 3. All clinical staff was in serviced on Neglect, Identification, Investigation, Documentation, Patient Assessment, Addressing Recommendations Timely, and Notification by 8/14/2012 by the Director of Nurses, the Administrator or Unit Supervisor. All clinical staff was also in serviced on the use of the twenty-four hour report by the Director of Nurses, the Administrator and or the Unit Supervisor by 8/14/2012. The Interdisciplinary Care Plan Team which consist of the Director of Nurses, MDS Coordinators, Social Services Director, Environmental Services Director , Dietary Manager, Wound Care Nurse and Activities Director were in serviced by the Administrator by 8/14/2012 on Neglect, Identification, Investigation, Documentation, Patient Assessment, Notification; and use of the 24 hour report for communication. The twenty- four hour report will be collected each day by the Unit Supervisor and reviewed to identify events that require notification. On the weekends and on holidays the Unit	

review of physician Orders to ensure needs given timely

8/21/12 8:40 AM. phone call to Lisa Leach DON - she will correct page 59 & resubmit.

Lisa will add info.

also collaboration of mental health provider on revision/clarification of mental health assessment forms. who responsible? S.S.

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F 309	Continued From page 59 Medical record review of a nurse's note dated June 6, 2012, at 9:00 a.m., revealed, "...went out to patio and threatening to climb fence..." Medical record review of a nurse's note dated June 10, 2012, revealed, "(6A-6P) (6:00 a.m. -6:00 p.m.)...unable to concentrate any length of time on any one thing..." Medical record review of a nurse's note dated June 17, 2012, at 2:00 p.m., "called to resident's room screen removed from window and resident attempting to climb out redirected while staff was attempting to fix window but resident continues to attempt to leave...will cont (continue) to monitor." Medical record review of a nurse's note dated June 17, 2012, at 9:30 p.m., revealed, "Responded to CNA (Certified Nursing Assistant) calling out. Went to resident's room to see CNA holding resident to keep (resident) from falling out of open window onto the ground. Resident had pushed screen out and attempted to climb out of window. This nurse was told the resident had made the same attempt earlier today...Will monitor." Medical record review of a Psychotropic Medication Evaluation dated July 4, 2012, at 12:01 p.m., revealed, "...presents with severe insomnia...staff reported episodic mood swings...some inc (increased) delusions...Rationale for Recommendations...also may increase haldol 2 mg 1/2 tab (tablet) afternoon in addition to bid dose prn (as needed)..." Continued review revealed the recommendations were approved by a nurse practitoner on July 20, 2012. Medical record review of a Psychotropic Medication Management Progress Note dated July 13, 2012, at 12:45 p.m., revealed,	F 309	Supervisor will review the twenty four hour report and via copy submit the twenty four hour report to the daily Quality Assurance Meeting on normal business days. Recommendations that are identified will be reviewed for compliance and results will be reported to the Interdisciplinary Care Plan Team which consist of the Director of Nurses, MDS Coordinators, Social Services Director, Environmental Services Director, Dietary Manager, Wound Care Nurse and Activities Director; whom will also review for effectiveness. The Director of Nurses will review results to ensure compliance. The Administrator spoke to the Mental Health Services Field Operations Manager on August 1, 2012. The Paradigm Health Services was required to provide a performance improvement plan. The Director of Nurses or Unit Supervisor will forward all medication recommendations to the Nurse Practitioner and or the Medical Doctor.	

Revised page

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F 309	Continued From page 60 "...appeared vigilant and paranoid. Staff reported '...has been crazy...staff reported inc paranoia as dementia escalates. Current c/o (complaint) inc (include) physical aggression and irritability. Plan: inc haldol 2 mg tid (three times daily)...Indications for next visit: Acute Behavioral/Medical Problem...Delusions...Judgment Impaired...Ambulatory ...SI/HI (suicidal/homicidal ideation) Unable to assess due to patient's cognitive impairment..." Continued review revealed the Progress Note was not reviewed by a physician or a nurse practitioner until July 23, 2012, and included, "...Accept..." Medical record review of a physician's order dated July 23, 2012, revealed, "Haldol (an antipsychotic medication) 1 mg (milligram) @ (at) noon." Medical record review of a nurse's note dated July 13, 2012, at 5:35 p.m., revealed, "Resident hollering that (resident) wanted to (go) home, that we have no right to keep...against (resident's) will...Going outside in enclosed area and attempting to climb fence..." Medical record review of a nurse's note dated July 14, 2012, revealed, "@ (at) 1 pm (1:00 p.m.) window alarm sounding resident with one leg out window redirected back in window...Helped resident to bed covered with blanket and exited room." Medical record review of a nurse's note dated July 14, 2012, at 1:30 p.m., revealed, "resident continuing to attempt to climb out window...RN (Registered Nurse) notified of situation...will continue to monitor." Medical record review of a nurse's note dated July 16, 2012, at 9:00 a.m., revealed, "...wandering...exit	F 30	4. The Director of Nursing or Unit Supervisor will review the twenty-four hour reports daily to ensure timely communication of recommendations including medication orders, psychiatric recommendations, mental health orders and medication recommendations to the Physician or Nurse Practitioner on changes in a resident's status, psychiatric recommendations, and to ensure compliance. The twenty-four hour report will be brought to the daily Quality Assurance Meeting on business days by the Unit supervisor. On weekends and holidays the unit supervisors will review the twenty-four hour report and present the findings to the Director of Nurses on the next business day via a copy of the twenty-four hour report. The Director of Nurses, the Social Services Director and MDS Coordinators will perform three chart reviews a week to ensure that the facility maintains the highest practicable physical, mental and psychosocial well-being, in accordance with the comprehensive assessment and plan of care going forward. The findings of the reviews will be discussed in the monthly Quality Assurance Meeting for three months to ensure compliance is met. The Director of Nurses will review results	

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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 309	Continued From page 61 seeking shaking door to leave...will cont to monitor." Medical record review of a nurse's note dated July 17, 2012, at 9:00 a.m., revealed, "...continuously asking...when am I going home ...will cont to monitor." Medical record review of a nurse's note dated July 17, 2012, at 6:15 p.m., revealed, "...Exit seeking, trying to remove screen in window and climb over fence on patio. Unable to redirect..." Medical record review of a nurse's note dated July 19, 2012, at 2:30 p.m., revealed, "...Res. (resident) crying today...wanted to go home. At one time...yelled...and ran out back door...Will cont. to monitor behavior and attempt to redirect." Medical record review of a nurse's note dated July 19, 2012, at 7:40 p.m., revealed, "(CNA (#2) came running over to South Station where I was on a med (medication) cart....said (resident) was out side, over at apartment complex ...(CNA #1) was on lunch and came driving back to nursing home and seen (resident) running up the road to apartment complex...saw (resident) go into apartment #124...the police came and helped get (resident) back to (secure unit)..." Medical record review of the Medication Administration Record dated July 2012 revealed the resident was administered Haldol 2 mg. at 8:00 a.m. and 8:00 p.m. from July 1, 2012, through July 23, 2012. Continued review revealed administration of Haldol 1 mg. at 12:00 p.m., was not initiated until July 24, 2012, at 12:00 p.m., twenty days following the first recommendation (of July 4, 2012) to increase the resident's medication, ten days after the resident's third elopement attempt (on July 14, 2012), and five days after the resident's	F 309	to ensure compliance. The Administrator or the Director of Nurses will lead the Quality Assurance Meeting each month to ensure that the items that are being reviewed are effective and to identify any additional areas of concerns that may be presented or as a result of the Quality Assurance Meeting going forward.	

Revised Page

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F 309	Continued From page 59 Medical record review of a nurse's note dated June 6, 2012, at 9:00 a.m., revealed, "...want out to patio and threatening to climb fence..." Medical record review of a nurse's note dated June 10, 2012, revealed, "(6A-6P) (6:00 a.m. -6:00 p.m.)...unable to concentrate any length of time on any one thing..." Medical record review of a nurse's note dated June 17, 2012, at 2:00 p.m., "called to resident's room screen removed from window and resident attempting to climb out redirected while staff was attempting to fix window but resident continues to attempt to leave...will cont (continue) to monitor." Medical record review of a nurse's note dated June 17, 2012, at 9:30 p.m., revealed, "Responded to CNA (Certified Nursing Assistant) calling out. Went to resident's room to see CNA holding resident to keep (resident) from falling out of open window onto the ground. Resident had pushed screen out and attempted to climb out of window. This nurse was told the resident had made the same attempt earlier today...Will monitor." Medical record review of a Psychotropic Medication Evaluation dated July 4, 2012, at 12:01 p.m., revealed, "...presents with severe insomnia...staff reported episodic mood swings...some inc (increased) delusions...Rationale for Recommendations...also may increase haldol 2 mg 1/2 tab (tablet) afternoon in addition to bid dose prn (as needed)..." Continued review revealed the recommendations were approved by a nurse practitoner on July 20, 2012. Medical record review of a Psychotropic Medication Management Progress Note dated July 13, 2012, at 12:45 p.m., revealed,	F 309	Supervisor will review the twenty four hour report and via copy submit the twenty four hour report to the daily Quality Assurance Meeting on normal business days. Recommendations that are identified will be reviewed for compliance and results will be reported to the Interdisciplinary Care Plan Team which consist of the Director of Nurses, MDS Coordinators, Social Services Director, Environmental Services Director, Dietary Manager, Wound Care Nurse and Activities Director; who will also review for effectiveness. The Director of Nurses will review results to ensure compliance. 4. The Director of Nursing or Unit Supervisor will review the twenty-four hour reports daily to ensure the timely communication of recommendations are being given to the Physician or Nurse Practitioner on changes in a resident's status, psychiatric recommendations, and to ensure compliance. The twenty- four hour report will be brought to the daily Quality Assurance Meeting on business days by the Unit Supervisor. On weekends and holidays the unit	

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F 309	Continued From page 80 "...appeared vigilant and paranoid. Staff reported "...has been crazy...staff reported inc paranoia as dementia escalates. Current c/o (complaint) inc (include) physical aggression and irritability. Plan; inc haldol 2 mg tid (three times daily)...Indications for next visit: Acute Behavioral/Medical Problem...Delusions...Judgment Impaired...Ambulatory ...SI/HI (suicidal/homicidal ideation) Unable to assess due to patient's cognitive impairment..." Continued review revealed the Progress Note was not reviewed by a physician or a nurse practitioner until July 23, 2012, and included, "...Accept..." Medical record review of a physician's order dated July 23, 2012, revealed, "Haldol (an antipsychotic medication) 1 mg (milligram) @ (at) noon." Medical record review of a nurse's note dated July 13, 2012, at 5:35 p.m., revealed, "Resident hollering that (resident) wanted to (go) home, that we have no right to keep...against (resident's) will::Going outside in enclosed area and attempting to climb fence..." Medical record review of a nurse's note dated July 14, 2012, revealed, "@ (at) 1 pm (1:00 p.m.) window alarm sounding resident with one leg out window redirected back in window...Helped resident to bed covered with blanket and exited room." Medical record review of a nurse's note dated July 14, 2012, at 1:30 p.m., revealed, "resident continuing to attempt to climb out window...RN (Registered Nurse) notified of situation...will continue to monitor." Medical record review of a nurse's note dated July 16, 2012, at 9:00 a.m., revealed, "...wandering...exit	F 309	supervisors will review the twenty four hour report and present to the findings to the Director of Nurses on the next business day via a copy of the twenty four hour report. The Director of Nurses, the Social Services Director and MDS Coordinators will perform three chart reviews a week to ensure that the facility maintains the highest practicable physical, mental and psychosocial well-being, in accordance with the comprehensive assessment and plan of care going forward. The findings of the reviews will be discussed in the monthly Quality Assurance Meeting for three months to ensure compliance is met. The Director of Nurses will review results to ensure compliance. The Administrator or The Director of Nurses will lead the Quality Assurance Meeting each month to ensure that the items that are being reviewed are effective and to identify any additional areas of concerns that may be presented or as a result of the Quality Assurance Meeting going forward.	

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F 323	Continued From page 73 Review/Recommendations...Ensure Alarm on Window Working...Resident was out of facility approximately 10- 15 mins (minutes) (estimate) ...Approxdmate Distance 50 - 75 ft (feet)." Continued review revealed the form was not dated or signed. Review of a "Monthly Window Alarm Test for Greenbriar" (secure unit) dated 2012 revealed the alarm in the resident's window was tested in June and included, "OK." Continued review revealed no documentation for testing window alarms of the secure unit in July 2012 as of July 27, 2012. Review of the facility investigation and a witness statement dated July 19, 2012, revealed, "I...(RN #1) was working the med (medication) cart on South Station, about 8 pm (p.m.)...CNA came running...told me (resident) was out side over at apartment complex...I ran over to Greenbriar (secure unit) to see if it was really (resident), when I went into Greenbriar...(Licensed Practical Nurse (LPN) #1) was doing...med cart, (LPN #1) did not know that (resident) was gone, I went to dinning (dining) room no (resident) . I ran down the hall to (resident's) room, the door was shut, I could not hear the alarm, I opened the door and I could hear the alarm but it was not very loud, the window was open...(resident) was gone, I ran to the apartment complex next door the police was bring (bringing) (resident) back to the nursing home in (police) car..." Review of the facility investigation and a statement by (LPN #1) dated July 19, 2012, revealed, "...at approximately 0740 pm- 800 pm (7:40 p.m.-8:00 p.m.) I was in the process of self-orienting myself to e-charting and the e-mar	F 323		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 323	Continued From page 74 (electronic charting and electronic Medication Administration Record)...at the desk...(RN #1) enters the unit and says...has been told a resident has eloped from the unit. I...was unaware of this...and we both proceeded rapidly to (resident's) room...An alarm, which was inaudible standing immediately outside the closed door, was sounding...(resident) was returned to the unit by a law enforcement officer..." Review of the facility investigation and a statement by CNA #1 dated July 19, 2012, revealed, "While I was out on my lunch break I noticed (resident) running around in the yards over at the fairgrounds (an apartment complex). I asked if I could give...a ride back ...hit me 3 times. That's when I realized it was going to take more than me to get...back...(CNA #2) was at the front door...to let some family members out...The family members followed us over and asked what (resident) looked like...They told me to get in with them and they would drive me around to see if I could find (resident). I happened to see a man across the street pointing towards an apartment...the woman that was with us said I'm a nurse let me take care of this. She knocked on the door and said she was calling the law. Her husband called 911. The cops showed up and (RN #1) and (Maintenance Director) was walking over...the cop took (resident) over to the nursing home..." Review of the facility investigation dated July 25, 2012, revealed, "...Date of Alleged Event: 07/19/2012...was in own room, opened the window, and crawled out of window (resident)...running down the road...Resident had just left the facility when seen by the CNA in the	F 323		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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PRINTED: 08/03/2012
FORM APPROVED
OMB NO. 0938-0391

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F 323	Continued From page 75 fair grounds (apartment complex) no more than 15 minutes...The LPN and the CNAs did not hear the alarm going off in the room due to the door was shut..." Review of the facility investigation revealed no documentation regarding when and by whom the resident was last seen prior to the observation by CNA #1 of the resident outside the facility on July 19, 2012. Observation on July 26, 2012, at 10:15 a.m., revealed the door to the resident's room was closed. Observation on July 26, 2012, revealed a security camera on the nurse's station displayed views of the two exit doors from the unit and the day/activity room. Observation on July 26, 2012, at 2:07 p.m., revealed the resident asleep in bed, the room was the first room from the exit door to the courtyard and furthest from the nurse's station, and a fenced courtyard was visible through the resident's window. Continued observation revealed an alarm sounded when the exit door was opened. Observation on July 26, 2012, at 3:02 p.m., revealed the resident independently walked with a steady gait to the nurse's station and stated, "I wanna (want to) go home. I love you. Can I go home with you?" Observation on July 27, 2012, at 10:25 a.m., revealed the resident asleep on the bed and the door to the room was open. Observation on July 27, 2012, at 11:27 a.m., revealed the resident seated at a table in the dining room. Interview with the Maintenance Director on July 27, 2012, at 11:57 a.m., in a conference room, revealed alarms had been placed on every window of the secure unit for at least two years,	F 323		

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F 323	Continued From page 76	F 323		

Continued interview revealed operation of the alarms was tested monthly and the alarm was tested the evening the resident eloped (after the elopement). The Maintenance Director stated, "...If you were at the desk (you) could not hear it. You'd have to be close to it. (There is) no way to adjust the volume." Interview with the Maintenance Director on July 27, 2012, at 12:17 p.m., in a conference room, revealed the Maintenace Direcotor was unaware the resident had attempted to elope through the window of the resident's room prior to the elopement on July 19, 2012.

Observation with the Maintenance Director on July 27, 2012, at 12:55 p.m., revealed the distance from the bottom of the resident's window to the ground of the parking lot was thirty-four inches. Continued observation revealed the time required to walk from outside the resident's window to the apartment from which the resident was returned to the facility was less than three minutes. Continued observation revealed the area outside the resident's window included the facility's parking lot adjoining a wooded area; a drainage ditch, and intersection of two public streets.

Observation on July 30, 2012, at approximately 9:30 a.m., revealed an industrial park, a water treatment plant, and a bridge over a creek less than a minute from the facility driving at twenty miles per hour (the posted speed limit).

Interview with the DON on July 27, 2012, at 1:37 p.m., in a conference room, revealed LPN #1, CNA #3, and CNA #4 were assigned to the secure unit at the time the resident eloped on July

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUMMIT VIEW OF LAKE CITY, LLC	234 INDUSTRIAL PARK RD LAKE CITY, TN 37769

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 77 19, 2012. Continued interview revealed the facility's investigation did not include statements from CNA #3 or CNA #4. Interview with CNA #1 on July 27, 2012, at 1:45 p.m., in a conference room, revealed CNA #1 had left the facility for lunch at approximately 7:00 p.m. and on returning from lunch observed the resident out of the facility. Continued interview revealed the resident was on the far side of the second street from the facility, and CNA #1 stated, "...I noticed (resident) right there on the side of the road straight across the street from (the) apartment where (resident) was at...hit me two to three times right up the side of the head...decided I needed more help...I got to the road to turn in here, looked back and saw (resident) running toward that apartment. Saw (resident) go up the steps...That shocked me that (resident) was that far and nobody noticed..." Medical record review of the resident's care plan dated April 23, 2012, and interview with MDS Coordinator #1 on July 27, 2012, at 2:05 p.m., in a conference room, revealed the care plan was the resident's current care plan. Continued interview confirmed the resident's care plan had not been revised to address the resident's recurrent attempts and history of elopement. Interview with the Director of Nursing and the Administrator on July 27, 2012, at 2:20 p.m., revealed the DON had no additional investigations regarding elopment attempts by the resident. Continued interview revealed the twenty-four hour communication book had no documentation regarding the resident's previous elopement attempts. Continued interview	F 323		

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SUMMIT VIEW OF LAKE CITY, LLC	2-4 INDUSTRIAL PARK RD LAKE CITY, TN 37769

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F 323	Continued From page 78 confirmed the facility had failed to provide adequate supervision and/or safety device to ensure the resident with recurrent elopement attempts did not elope from the facility. The DON stated, "...have spoken to all RN managers. All say they were unaware of (resident's) previous attempts to elope. The only knowledge (DON's) of resident's behavior was the elopement..." In summary, the facility failed to provide adequate supervision for Resident #3 following elopement attempts on June 17, 2012, and July 14, 2012, and the resident successfully eloped from the facility on July 19, 2012. Corrective actions which removed the immediacy of the jeopardy, included one on one supervision of the resident while installation of additional alarms to the windows on the secure unit was completed, assessment and care plan revision for the resident and other resident's at risk, revision of policies and procedures regarding identification, investigation, and notification of unusual occurrences including abuse and/or neglect and staff education. The surveyor verified the corrective actions on July 30, 2012, by observation, medical record review, policy review, and interview. Non-compliance continues at a "D" level for monitoring corrective actions through the facility's Quality Assurance/Performance Improvement Program. The facility is required to submit a plan of correction. Refer to F157-J. Refer to F224-J, Substandard Quality of Care.	F 323		

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PRINTED: 08/08/2012
FORM APPROVED
OMB NO. 0938-0391

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUMMIT VIEW OF LAKE CITY, LLC	284 INDUSTRIAL PARK RD LAKE CITY, TN 37769

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F 323	Continued From page 79 Refer to F225-J, Substandard Quality of Care. Refer to F250-J, Substandard Quality of Care. Refer to F272-J. Refer to F280-J. Refer to F309-J, Substandard Quality of Care. C/O: #30197	F 323		
F 490 SS=J	483.75 EFFECTIVE ADMINISTRATION/RESIDENT WELL-BEING A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on medical record review, facility policy review, review of facility investigations, review of window alarm monitoring documentation, observations and interviews, the facility failed to administer care in a manner to assess and notify the physician of recurrent unsafe behaviors, failed to prevent neglect, failed to thoroughly investigate recurrent elopement attempts and/or an elopement, failed to provide required social services, failed to revise the care plan to address recurrent unsafe behavior, failed to timely communicate recommendations for an increase in an antipsychotic medication, failed to provide adequate supervision and/or security device to prevent elopement for one resident (Resident #3) of seven sampled residents. The Administrator failed to ensure processes were in place to notify the physician, prevent	F 490	Requirement: The facility will be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. Corrective Action: 3 All Clinical Staff was in serviced on Neglect, Identification, Investigation, Documentation, Patient Assessment, Addressing Recommendations Timely, and Notification by 8/14/2012 by the Director of Nurses, the Administrator and or the unit Supervisor. All clinical staff was also in serviced on the use of the twenty-four hour report by the Director of Nurses, the Administrator and or unit supervisor by 8/14/2012. The Interdisciplinary Care Plan team which consist of the Director of	8/17/2012

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F 490	Continued From page 80 neglect, investigate, provide social services, revise the care plan, communicate medication recommendations, and provide adequate supervision and/or security devices for repeated attempts to elope and the successful elopement by Resident #3 resulted in Immediate Jeopardy (a situation that is likely to cause serious injury, harm, impairment, or death). The Administrator and Director of Nursing (DON) were notified of the Immediate Jeopardy on July 30, 2012, at 12:38 p.m., in the Administrator's office. The Immediate Jeopardy was effective June 17, 2012, through July 24, 2012. The findings included: Resident #3 removed a window screen and attempted to elope from the facility on June 17, 2012, at 2:00 p.m., attempted to elope through a window on June 17, 2012, at 9:30 p.m., and attempted to elope through a window on July 14, 2012, at 1:00 p.m. Interview with Minimum Data Set Coordinator (MDS Coordinator) #1 on July 27, 2012, at 2:05 p.m., in a conference room, confirmed the facility failed to revise the resident's care plan to address recurrent attempts to elope and/or actual elopement. Interview with the DON and the Administrator on July 27, 2012, at 2:20 p.m., in the DON's office, revealed no knowledge regarding the resident's attempts to elope two times on June 17, 2012. Continued interview revealed the DON had	F 490	Nurses, MDS Coordinators, Social Services Director, Environmental Services Director , Dietary Manager , Wound Care Nurse and Activities Director were in serviced by the Administrator by 8/14/2012 on Neglect, Identification, Investigation, Documentation, Patient Assessment, Notification; and use of the 24 hour report for communication. The twenty- four hour report will be collected each day by the Unit Supervisor and reviewed to identify events that require notification. On weekends the 24 hour reports will be reviewed by the unit supervisor and the results will be reviewed in the Daily Quality Assurance Meeting on the next business day. Systems that are identified to be deficient will be reviewed for effectiveness by the Administrator and results will be reported to the Interdisciplinary Care Plan Team which consist of the Director of Nurses, MDS Coordinators, Social Services Director, Environmental Services Director, Dietary Manager, Wound Care Nurse and Activities Director; whom will also review for effectiveness. The Administrator will continually monitor systems	

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OMB NO. 0938-0391

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F 490	Continued From page 81 reviewed the twenty-four hour communication book and spoken with nursing managers. The DON stated, "...all say they were unaware of previous attempts to elope..." Continued interview revealed no reports of elopement attempts had been made and the facility had no investigations into the resident's attempts to elope prior to July 19, 2012. Interview with the DON on July 30, 2012, at 12:15 p.m., in a conference room, revealed the DON was unaware of the initiation of one on one supervision for Resident #3 on July 19, 2012, and unable to determine the duration of the one on one supervision. Telephone interview with the resident's physician (Medical Doctor) (M.D. #1) on July 30, 2012, at 12:20 p.m., in the administrator's office and in the presence of the Director of Nursing (DON) and the Administrator, revealed M. D. #1 was unaware of the resident's attempts to elope from the facility on June 17, 2012, and July 14, 2012. Continued interview confirmed the recommendations for changes in the resident's antipsychotic medication were not communicated or acted on in an effective, timely manner and timely administration of the increased dose of antipsychotic medication may have improved the resident's behavior and prevented the resident's elopement on July 19, 2012. Interview with the Social Service Director (SSD) on July 30, 2012, at 11:00 a.m., in a conference room, revealed the resident's risk for elopement was discussed in a care plan meeting on July 3, 2012, and the resident's recurrent attempts to elope were not discussed. Continued interview	F 490	associated with Neglect, Identification, Investigation, Documentation, Patient Assessment, Notification; and use of the 24 hour report for communication for effectiveness to prevent the presence of deficient practices. 1. The Unit Supervisor will review the twenty-four hour reports daily to ensure that notification is being provided to the Physician and or Nurse Practitioner on changes in a resident's status, and to ensure compliance. On weekends and holidays the twenty four hour report will be reviewed by the unit supervisor and a copy will be reviewed by the Director of Nurses on the next business day. The twenty-four hour report will be brought to the daily Quality Assurance Meeting by the Unit Supervisor. The Director of Nurses will perform three chart reviews a week to ensure compliance is met for Neglect, Identification, Investigation, Documentation, Patient Assessment, Notification; and use of the 24 hour report for communication. The Administrator will review the Window Alarm System checks weekly as a new standard of practice going	

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F 490	Continued From page 82 revealed the SSD was uncertain if the resident was currently treated by a mental health provider. Interview with Registered Nurse (RN) #2 on July 30, 2012, at approximately 4:00 p.m., revealed RN #2 completed the elopement risk assessment dated July 3, 2012. RN #2 stated, "The assessment is incorrect. I did it. It's solely my responsibility." Interview with the DON on July 30, 2012, at approximately 4:15 p.m., in the DON's office, confirmed the facility neglected to provide the care required by Resident #3. The DON stated, "...We missed every opportunity..." The facility neglected to act to address the resident's repeated attempts to elope and Resident #3 successfully eloped from the facility through a window on July 19, 2012. Corrective actions which removed the immediacy of the jeopardy, included one on one supervision of the resident while installation of additional alarms to the windows on the secure unit was completed, assessment and care plan revision for the resident and other resident's at risk, and revision of policies and procedures and staff education regarding identification, investigation, and notification of unusual occurrances including abuse and/or neglect. The surveyor verified the corrective actions on July 30, 2012, by observation, medical record review, policy review, and interview. Non-compliance continues at a "D" level for monitoring of corrective actions. The facility is	F 490	orward. The findings of all of the eviews will be discussed in the monthly Quality Assurance Meeting or three months to ensure compliance is met. The Administrator or Director of Nursing will lead the Quality Assurance Meeting each month to ensure that the items that are being reviewed are effective and to identify any additional areas of concerns that may be presented or as a result of the Quality Assurance Meeting going forward.	

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OMB NO. 0938-0391

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F 490	Continued From page 83 required to submit a plan of correction. Refer to F157 J. Refer to F224 J, Substandard Quality of Care. Refer to F225 J, Substandard Quality of Care. Refer to F250 J, Substandard Quality of Care. Refer to F272 J. Refer to F280 J. Refer to F309 J, Substandard Quality of Care. Refer to F323 J, Substandard Quality of Care.	F 490		